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FIRST ANNUAL REPORT

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MENTAL DISABILITIES BOARD OF VISITORS

to

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THE GOVERNOR OF THE STATE OF MONTANA

June 30, 1976

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MENTAL DISABILITIES BOARD OF VISITORS  
FIRST ANNUAL REPORT TO THE GOVERNOR  
6/30/76

Introduction

This is the first annual report of the Montana Mental Disabilities Board of Visitors to the Honorable Governor of the State of Montana. This report is issued in accordance with R.C.M. 38-1330(8) (1947 as amended 1975).

The Board of Visitors came into existence by virtue of Governor's appointments of the following people effective on the following dates:

Dr. J. Francis Rummel	Missoula	11/5/75
Dr. Donald Harr	Billings	11/5/75 (resigned prior to 4/1/76)
Ms. Gay Ashton	Helena	11/5/75
Mr. Aage Hansen	Helena	11/5/75
Dr. L. A. Hamerlynck	Helena	11/5/75
Dr. Jack Stimpfling	Great Falls	4/29/76

The first meeting of the Board of Visitors was held on December 4, 1975. Dr. Rummel was elected Chairman and Dr. Hamerlynck was elected Secretary.

As will be pointed out later in this report, the Board of Visitors has adopted a policy of relying on the reports made by other agencies and organizations when the credibility of those reports is not questioned by the Board of Visitors. Some of the observations contained in this report originated, not with the Board of Visitors, but with people visiting and reporting on a facility for a purpose not directly related to the specific work of this Board. Likewise, consultants have been employed from time to time by this Board to accompany and assist this Board during visits to facilities coming under this Board's purview. References to such consultants and their reports will be made in this report, copies of their findings will be made a part of this report, and an up-to-date list of consultants used by this Board will be included in the appendix to this report (see Appendix 1-A).

Since its inception seven months ago, the Board of Visitors has put most of its effort into developing a sound policy statement and an effective

organizational structure (see Appendix 2-A). The Board has also taken steps to acquaint itself with the system of facilities which come under the jurisdiction of the Board (see Appendix 2-B for Board By-Laws).

Because the Board of Visitors has been in existence for only seven months, time has not permitted an examination of all of the facilities under its jurisdiction to the extent needed for a detailed and accurate annual report.

With the exception of the psychiatric wards of medical hospitals, and the satellite centers of the community mental health centers, all of the facilities under the jurisdiction of this Board were visited by the Board or one of its members.

Set out below is a brief summary of the on-site visits by the Board of Visitors to facilities under its jurisdiction.

#### I. Community Mental Health Centers

Region I. The Mental Health Center for Region I is located in Miles City and was visited by Board members Aage Hansen and Gay Ashton on April 6, 1976. The Center had a pleasant and well located physical plant. The program seeks to meet the needs of a large rural area. The Center appeared to coordinate its satellite centers throughout Region I. Two day care centers serve the area and thought is being given to developing lodging for clients traveling overnight for Center services. Region I has an approximation of a peer review system for some prescribed medications prescribed by their in-house psychiatrist.

Region II. The Mental Health Center for Region II is located in Great Falls and was visited by Board members Aage Hansen and Gay Ashton on

April 7, 1976. The Center is located in a large suburban shopping center. The Center reports it has outgrown its present facilities and is currently looking for a new facility. The day care center is located on the other side of town.

There is no apparent understanding of community program needs, however, an intensive needs assessment is in progress which, hopefully, will give new direction to program planning. Region II does not have a formal peer review system for many aspects of its work and no peer review system at all for the medications prescribed for its clients.

Region III. The Southcentral Comprehensive Mental Health Center is located in Billings and was visited on December 4, 1975 by Dr. Rummel, Dr. Hamerlynck, Gay Ashton, Aage Hansen and Dr. Donald Harr of the Board of Visitors. The Center is housed in an attractive building in a hospital complex easily accessible to clients.

Program planning in Region III appears to be adequate, particularly within the city of Billings and the county of Yellowstone. Concerted effort has been made to inform the citizens of Region III of the mental health services available through the Center.

Region IV. The Southwestern Comprehensive Community Mental Health Center is located in Helena and was visited by Drs. Rummel, and Hammerlynck, Ms. Ashton, and Aage Hansen on February 18, 1976. This Center, the last one to be formed in Montana, has been plagued with personnel problems as well as the problem involved with serving two large cities, Helena and Butte within Region IV. Gallatin County does not participate in the funding of Region IV, therefore, the services of the Center in Region IV are not extended to the Bozeman area.

Region IV has a new director and he has plans to update the treatment plan methods of the Center and to increase the amount of in-patient treatment



done through the Center.

Region V. The Western Mental Health Center is located in Missoula and housed at Fort Missoula, a couple of miles from the center of town. This Center was visited by Dr. Rummel, Dr. Hamerlynck and Gay Ashton on March 12, 1976 and was reported to be rather severely under funded and therefore under staffed. Little effort has been made to inform the citizens of Region V of the mental health services available through the Center. The staff at the Center feels that increased awareness of the services of the Center would lead to a greater backlog because of the inadequate staffing. Region V is reported to be under funded because of a low federal staffing grant and because of limited local funds available for the Center.

The Center has recently undertaken an evaluation of its services wherein it has solicited comments and criticisms from clients served by the Center. This effort indicates a real attempt on the part of the Center to increase and improve its services.

## II. The Home for the Aged

The Home for the Aged located at Lewistown, Montana was visited on April 7, 1976 by Aage Hansen and Gay Ashton of the Board of Visitors. The Center is an attractive facility with very good programs available to the residents. A new wing which will add 64 beds to the facility is nearing completion, and some concern exists for the staffing of this new wing. The city of Lewistown has a new community hospital also nearing completion and a local private nursing home is likewise considering expansion. Both of these projects could deplete the number of qualified people available in the area and cause staffing problems for the Home for the Aged when its own expansion

project is completed. The Home for the Aged has a good working relationship with the local Mental Health Satellite Center and has begun working with the local Ministerial Association to create a "pool" of "responsible persons" to act on behalf of the residents of the Home for the Aged.

Administrators and staff at the Home for the Aged indicate some confusion exists regarding the legal status of many of the residents. With the enactment of Title 38, Chapter 13 of the Revised Codes of Montana by the Montana Legislature (1975), the status of those residents coming to the Home for the Aged from Warm Springs has not been clearly spelled out for the staff at the Home for the Aged by the Department of Institutions.

### III. Eastmont Training Center

The Eastmont Training Center, located at Glendive, Montana, was visited by Board member Aage Hansen. The visit was made to assess both the physical plant and the programs for providing residential care and training of retarded persons of school age.

The Center has a capacity of 32 students and at the time of the visit 26 were in residence. Students are referred by either parents or regional special education offices and each student is given a two week evaluation prior to acceptance by the Center. Students normally reside at the Center five days a week and return to their natural or foster homes on weekends and holidays. Nearly all of the students at Eastmont are from the surrounding area, therefore, travel to and from their homes each weekend is not a problem for either the parents or the staff at the Center. The Center utilizes the Glendive School District whenever possible.

With respect to the physical plant, many of the doors are too narrow for wheelchairs to pass through and there are inadequate means for fire escape from some of the basement rooms.



Habilitation and treatment plans have been developed and are being satisfactorily implemented as far as could be determined by the Board of Visitors. Plans are provided for academic development, self-help skills, development and training in speech, home living, recreation, socialization and pre-vocational training as they are needed and recommended for each student.

#### IV. Boulder River School & Hospital

A visit was made to the Boulder River School & Hospital on January 16, 1976 by Dr. Rummel, Dr. Hämerynck, Aage Hansen, Gay Ashton of the Board of Visitors and Dr. Donald Harr as consultant. Particular attention was given during this visit to the hospital and the pharmacy.

A visit to the pharmacy indicated that the unit was well organized and adequately met the needs of the patients and the staff.

At the hospital it appeared that each patient was given individualized attention and treatment commensurate with their needs.

The attitude of the staff and the volunteers at the hospital did not appear to present any particular problems with respect to the care and treatment of patients. An innovative in-service training program has been developed for the staff and was being carried out as planned.

The hospital administration has encouraged the formation of a Hospital-Parents Advisory Committee to assist the administration in formation of hospital policy.

While some of the patients' quarters appeared to be in good shape, others were found in dire need of cleaning. These findings of the Board of Visitors were communicated to Superintendent William Conyard (see Appendix 3-A and 3-B). Assurance was received by the Board of Visitors that an augmented housekeeping force had been created to provide more effective housekeeping services.

There was a clear lack of planned activities for patients in most of the cottages and an obvious need for more activities geared to the patients' levels of ability. Program planning and implementation appeared to be proceeding at a slow pace.

#### V. Warm Springs State Hospital

On January 15, 1976 a visit was made by the Board of Visitors to Warm Springs State Hospital (WSSH). Board members Rummel, Hamerlynck, Ashton and Hansen were present, together with consultant Donald Harr, M.D. The purpose of the visit was to gain an overall awareness of the adequacy and implementation of treatment plans and the adequacy of the physical facilities to carry out these plans.

Physical facilities: The physical plant appeared to be satisfactory with respect to safety and sanitary considerations. However, the buildings and wards were drab and dreary and not at all conducive to effective interpersonal relationships which are required to be a part of the individualized treatment plans.

The dining areas are clean and sanitary and the food appeared to be appetizing. In spite of the above observations, much improvement is needed with respect to making the wards and the dining areas more attractive and livable.

In some wards recreational programming was apparent but not sufficient, and in other wards there did not appear to be anything for the patients to do except sit and walk around.

Treatment plans: Treatment plans and implementation procedures had not been completed for all patients at the time of the visit. New patients are being evaluated and programs of treatment are being developed for them.

Treatment plans in the Forensic Units appeared to be individualized and there were treatment orders for the physical needs of the patients. However, in the maximum security unit, the security measures are so extensive that treatment activities are essentially prohibited. For a more detailed description see Appendix 4-A by the Board's medical consultant Dr. Harr.

General comments: There seemed to be an atmosphere of positive action and enthusiasm reflected in the staff, and staff-patient, patient-patient, and staff-staff rapport seemed adequate. However, the Board members were concerned about the institutional type of patient responses and lack of programmatic activities for patients; lack of therapeutic imagination; locked wards; and evasive administrative responses to direct inquiry.

The Board and its consultant met with the administrative personnel at the end of the visit, indicated to them its concerns and suggested that treatment plans for all patients be expedited and more programmatic activities be developed for patients. It was very evident that the administrators and staff have received little legal assistance in handling technical decisions regarding the requirements set forth in the recently enacted commitment law embodied in R.C.M. 38-1301 et. seq. and R.C.M. 38-1201 et. seq. (see also the Board's letter to the Director of Institutions calling attention to this situation, Appendix 4-B). The Board deemed a follow-up visit should be made, with a consultant team, in two to three months to make a more thorough exam-

ination of medical records and of the physical and psychological environment.

Follow-up visitation: On April 6-8, 1976, a follow-up visit to WSSH was conducted by Board member Hamerlynck and consultants Dr. John M. Atthowe (Ph.D), and Dr. Joseph M. Rochford (M.D.), both from Rutgers University Medical School (see Appendix 4-C and 4-D for copies of their vitae).

The specific purposes of this visit were:

1. To assess medical records with specific reference to medications;
2. To assess medical and other records for evidence of compliance with commitment processes and treatment plans;
3. To evaluate the records system in terms of its capability of supporting conditions of the law; and
4. To investigate the care and treatment of randomly selected patients as well as two patients the Board was asked by various persons to visit.

As a result of this visitation the team found that WSSH is failing to comply with the provisions of the law. The complete report of the WSSH review by the two consultants, dated April 30, 1976, included a list of several specific violations with reference to R.C.M. 38 (see Appendix 4-E for report). On May 3, 1976, the Board sent a letter to the Superintendent of WSSH with a copy of the consultants' report and list of violations with a request that the noted exceptions and violations be corrected without delay (see Appendix 4-F). The Superintendent was also requested to submit evidence of compliance or, when appropriate, a timeline for compliance to the Board of Visitors within 2 weeks of receipt of the notice.

On June 3, 1976, the Superintendent of Warm Springs answered the Board's letter and submitted his detailed reply to the specific items cited by the

Board of Visitors in the May 3, 1976 letter (see Appendix 4-G). The Superintendent's reply does not appear to address all of the issues involved in enough detail to warrant comment in this annual report. At its June 25, 1976 meeting, the Board voted to write a second letter to WSSH informing the Superintendent that his response to the Board's first letter was largely unsatisfactory and that several issues remain unaddressed. (See Appendix 4-H.) The Board of Visitors intends to follow its inspection and that of its consultants Drs. Atthowe and Rochford with subsequent inspections and inquiries to assure the care and treatment of all patients is in compliance with the law and in harmony with the needs of those patients.

#### VI. Galen

A site visit was made to the Galen State Hospital on June 14, 1976 by Board members Dr. Jack Stimpfling and Gay Ashton. A tour of all wards was conducted by Dr. Erin Higgins and Joseph Balkovatz. On the date of this visit there were 26 retarded females in residence and 38 retarded males. Sixteen higher functioning females had recently been moved from Annex II, where they had private rooms, to another unit where they were housed in two-bed rooms. The relocation and subsequent adjustments appeared to be smooth and well received by the patients. Activity seemed to be limited to TV and visiting. The retarded male patients are housed in Byram Hall with little or no organized activity outside of periodic movies.

The physical facilities are clean and orderly but there exists a conspicuous lack of planned activities for the residents, a shortcoming that was readily conceded by the staff. The staff expressed concern over the lack of planning for the eventual community placement of many of the residents. Likewise, the uncertain status of the mentally retarded population housed at Galen has given rise to a near critical situation with regard to budget and planning in general.



Near the end of the site visit, Mr. John Wolfe, director of the A.W.A.R.E. program in Anaconda met with the visitors and introduced them to his program. He hopes to expand this program to serve Galen residents in preparation for community living. The A.W.A.R.E. program is conducted in Anaconda and if Galen residents are to become participants they will commute to Anaconda from Galen each morning and back each afternoon. (See Appendix 7-A, Reports on Galen.)

#### Summary

During these first seven months of the Board's existence, emphasis has been placed on organization of the work of the Board, policy and procedures, and initial site visits to as many of the facilities under the Board's purview as time would allow (see Appendix 5-A and 5-B).

Among the areas which the Board was not able to address during its first seven months were experimental research and patient grievances. The Board is in the process of establishing a means by which patient grievances and incidents of unauthorized experimental research can be conveyed to the Board and a procedure by which the Board responds to and acts upon those complaints. As an interim measure, the Board has received cooperation from the Boulder River School & Hospital Human Rights Commission which has agreed to notify the Board of Visitors of any instances relating to experimental research or patient grievances coming to the attention of the Human Rights Commission (see Appendix 6-A).



RECOMMENDATIONS

The Board of Visitors would like to propose that a term of office for members of the Board of Visitors be set by law together with a method for removal from office for good cause shown. Examples of cause for removal might be; failure of a member to attend a specified number of Board meetings, or a breach by a Board member of confidential relationship which exists between the Board of Visitors and the patients under its purview.

The Board of Visitors also recommends immediate action toward J.C.A.H. accreditation for the WSSH. The Board of Visitors would like to see such effort become a priority item within the Department of Institutions. To expedite such accreditation, the Board suggests thought should be given to the reduction of the patient population at WSSH from the current 600 plus to less than 250. The Board suggests that J.C.A.H. accreditation cannot be attained without such reduction in patient population.

Although it is very early in the life of the Board of Visitors, the Board nonetheless would like to propose that it be given subpoena power to help carry out its statutory responsibilities without having to rely upon a local county attorney or a District Court judge for enforcement of its orders or requests. The Board notes that the Board of Visitors of the State of New York is equipped with subpoena power and finds that power to be extremely useful in getting action upon its requests for compliance with the laws of that state.

APPENDIX 1-A

CONSULTANT ROSTER

## CONSULTANT ROSTER

Following Board policy to utilize professional consultation, a roster of consultants is being compiled. When completed the Board will have ready access to expertise in the major areas of concern for both mental health and developmental disabilities and for institutional and community based programs. The professions of psychiatry, psychology, social work, psychiatric nursing, special education, law and medicine will be represented.

### CURRENT ROSTER

Dr. John Atthowe, Ph.D.  
Professor of Psychiatry  
Rutgers Medical School  
New Jersey

Dr. Joseph Rochford, M.D.  
Professor of Psychiatry  
Rutgers Medical School  
New Jersey

Dr. Donald Harr, M.D.  
Billings, Montana

Dr. Peter Roxburgh, M.D.  
Professor of Psychiatry  
University of Calgary  
Canada

Dr. Richard Stuart, D.S.W.  
University of New York at Stony Brook  
New York

Dr. Richard Jones, Ph.D.  
Oregon Research Institute  
Eugene, Oregon

Dr. Todd Risley, Ph.D.  
Department of Human Development  
University of Kansas  
Lawrence, Kansas

Dr. Ivar Lovas, Ph.D.  
Neuropsychiatric Institute  
U.C.L.A.  
Los Angeles, California

APPENDIX 2-A

POLICY & PROCEDURES FOR  
THE MENTAL DISABILITIES BOARD OF VISITORS

## POLICY &amp; PROCEDURES FOR THE MENTAL DISABILITIES BOARD OF VISITORS

The Board has set a goal to develop sound policy and procedures to guide it in its activities. The Board is also convinced that such policies and procedures are critical in assuring that the Board can maintain an equitable and effective system of inquiry and review.

1.0 Confidentiality: All actions of the Board and Board members are confidential and as a consequence written and verbal comments or reports must have formal Board approval. Although the Board has the authority to review all confidential records and documents relating to patient/clients it fully intends to assure that these documents are secure from non-authorized access. This is the primary reason for the adoption of this confidentiality rule.

2.0 Visitations and Reviews: The law establishing the Board is very clear in specifying the broad responsibility of the Board. However, it leaves the procedures for carrying out its task to the discretion of the Board. The following represent our attempt to codify our major activities.

2.1 The Board shall visit every facility in its jurisdiction at least two days each year. Such visits are to be publically announced and a schedule of activities provided to the facility prior to the visit. These visits will be referred to as annual-formal visits and require the presence of a majority of the Board.

2.2 Whenever possible the Board will utilize the reports of other federal, state, or professional review agencies. The requirement to assess the physical plant is one task where the Board intends to utilize the resources of other agencies. The intended result

of such arrangements is to allow the Board to focus upon patient/client treatment plans, grievances, etc. Any deficiencies detected by such reports will immediately be investigated by the Board. Confirmation will bring about immediate Board action as specified by law.

- 2.3 Individual Board members will visit facilities on a spot or unannounced basis at the direction of the Board or at their own discretion. Such visits will be conducted with respect for lines of authority at the facility whenever possible. The visitor should make every effort to review the visit with the director or superintendent. The purpose of this review is to apprise the administrator of the reasons for the visit - it will not be to summarize the results - which requires Board action.
- 2.4 Reports and recommendations from all visits and investigations are the responsibility of the Board. To expedite Board actions any member can arrange a phone conference which will address itself to specific deficiencies. The Board will exercise every caution in such phone conferences to validate evidence before taking formal action.
- 2.5 If a visit or investigation indicates a deficiency which does not directly and currently affect patient/client welfare, the Board will send a notice of deficiency to the superintendent or director of the facility. The notice will specify the deficiency in detail, suggest remedial action and specify a date by which the situation must be corrected and the Board informed of the



steps which the facility has undertaken. If for any reason the Board believes that the welfare of any client/patient may be directly and currently affected by a deficiency in a facility the Board shall take immediate action as required by law. The Board has adopted this policy and procedure to minimize the possibility of intrusion into treatment and professional services. However, the Board will not excuse any deficiency nor accept any compromise concerning the correction of deficiencies in any facility.

### 3.0 Commitment Reviews:

3.1 As the capability of the Board to review commitments is not yet fully developed, the following priorities have been established:

3.11 The Board will review in detail all new commitments made to institutions from July 1, 1976. The institutions will provide the Board with a report on all new admissions immediately upon arrival of the individual. This report should be in writing and of sufficient detail to identify the patient (use ID number other than name), court and judge involved as well as the name, address and phone number of the professional persons, responsible persons, guardians, etc. An immediate task for the Board will be to develop and distribute a simple standardized form to expedite this reporting process. Until this is done the institution should refer to the law for relevant information to be included.

- 3.12 The Board will review all voluntary commitment continuances or renewals of patients of record prior to July 1, 1976. Commitments covered by this section will be determined by the status of the individual prior to July 1, 1976, not by the nature of the commitment after that date.
- 3.13 Following the above actions the Board will expend every effort to fully attend to all remaining patients/clients. If this capability is not available then a sampling procedure for selection will be followed. Legal counsel on the staff of the Board will investigate the implications of this policy and revisions required to be made by such implications will be done.

4.0 Utilization of Consultants: In order to extend the professional and technical capability of the Board, consultants will be used to compliment Board visits. The consultants will be selected to provide specific service for problem areas (i.e., psychopharmacology to evaluate chemotherapy).

- 4.1 The consultants should represent the best possible expertise for the problem area as evidenced by credentials and affiliation.
- 4.2 Individual contracts will be made for each consultation with attention to confidentiality.
- 4.3 Generally, consultants will be recruited from out-of-state. This is dictated by the limited resources within Montana and the goals of complete objectivity in reports and impartiality of Board activities.
- 4.4 Complete identification will be secured for consultants to

facilitate access to confidential data. However, all consultant visits must be accompanied by a Board member.

APPENDIX 2-B

BY-LAWS

MENTAL DISABILITIES BOARD OF VISITORS

BY-LAWS

OF

MENTAL DISABILITIES BOARD OF VISITORS

ARTICLE I. NAME

The name of this organization shall be the Montana Mental Disabilities Board of Visitors.

ARTICLE II. PURPOSE

The purpose of this organization shall be:

Section 1. To operate and exist as an independent board of inquiry and review;

Section 2. To assure for each person who may be developmentally disabled such treatment and habilitation as will be suited to the needs of the person and to assure that such treatment and habilitation are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

Section 3. To assure that the goal set out in Section 2 is accomplished, whenever possible, in a community based setting;

Section 4. To assure that the goal set out in Section 2 above is accomplished in an institutional setting only when less restrictive alternatives are unavailable or inadequate and only when a person is so severely disabled as to require institutionalized care;

Section 5. To assure that due process of law is accorded any person coming under the provisions of this act;

Section 6. To assure for each person who may be seriously mentally ill or suffering from a mental disorder such care and treatment as will be suited to the needs of the person and to ensure that such care and treatment are skillfully and humanely administered with full respect for the person's dignity and personal integrity;

Section 7. To assure that a person is deprived of his or her liberty for purposes of treatment or care only when less restrictive alternatives are unavailable and only when his or her safety or the safety of others is endangered and to provide for due process of law when this is done.

Section 8. To assure that the treatment of all persons admitted to a residential facility as defined by R.C.M. 38-1202(9) or either voluntarily or involuntarily admitted to a mental facility as defined by R.C.M. 38-1302(6) is decent and humane and meets the requirements set forth in Title 38, Chapters 12 and 13 of the Revised Codes of Montana as adopted (1975).

## ARTICLE III. MEMBERSHIP

This organization shall have no members other than the five (5) members appointed by the Governor of the State of Montana, at least three (3) of whom shall not be professional persons and at least one (1) of whom shall be a representative of an organization concerned with the care and welfare of the mentally ill. No one may be a member of this organization who is an agent or employee of the Department of Institutions or of any mental health facility affected by this act.

## ARTICLE IV. BOARD

Section 1. Powers: The affairs of this organization shall be managed by the Board in accordance with R.C.M. 38-1330;

Section 2. Number and Tenure: The number of members shall be five (5) and they shall serve as members of the Board of Visitors at the pleasure of the Governor of the State of Montana;

Section 3. Annual Meeting: The regular annual meeting of the Board of Visitors shall be held during the month of May upon timely notice to all members. The annual meeting shall be held within Montana for the purpose of writing the annual report to the Governor and of transacting such other year end business as may come before the Board;

Section 4. Meetings: The Board shall meet at a date and a time specified in a notice to members after agreed upon by a majority of the members. The business to be transacted at such meetings shall be specified in the notice of such meetings;

Section 5. Quorum: Three (3) shall constitute a quorum for the transaction of business at any meeting of the Board, but if less than four (4) of the members are present at said meeting, a majority of those members present may adjourn the meeting from time to time without notice;

Section 6. Manner of Acting: The act of at least three (3) of the members of the Board shall be the act of the Board and shall be binding upon the Board and those entitled to or required to rely upon such action;

Section 7. Vacancies: Any vacancy occurring in the Board of Visitors shall be filled by appointment of the Governor of the State of Montana;

Section 8. Informal Action by Members: Any action required by law or otherwise necessary for the operation of this Board may be taken without a meeting if a consent in writing, setting forth the action so taken, shall be signed by three (3) of the members;



Section 9. Election of Officers: The Board shall elect annually one member to serve as Chairman and one member to serve as Vice Chairman-Secretary. Nothing in these by-laws shall prohibit the reelection of an officer;

Section 10. Expense Reimbursement: Members shall receive compensation in accordance with State regulations and shall be reimbursed for their actual expenses in connection with their services as members of the Board of Visitors.

#### ARTICLE V. EMPLOYEES

The Board shall appoint and employ such staff as is required to carry out its duties and responsibilities set out in Chapters 12 and 13 of Title 38 of the Revised Codes of Montana (1975).

#### ARTICLE VI. REPORTS AND RECORDS AND BOOKS

The Board shall keep correct and complete books and records of account of all funds appropriated to and expended by this Board. The Board shall keep minutes of all meetings of the Board together with minutes of all on-site visits by this Board or any of its agents acting on behalf of this Board. Any and all minority reports prepared by one or more members of this Board shall be kept with the minutes of the meeting or visit during which the dissenting or concurring opinion of one or more members was registered. Such minority reports shall remain the permanent record of this Board the same as any report adopted by the full Board. The Board shall keep at its office in Helena, Montana, a record of the names and addresses of the members of the Board. All books and records of the Board may be inspected by any member of this Board for any proper purpose, upon notice to the Chairman. The reports and books and records of this Board shall remain confidential in accordance with R.C.M. 38-1329. Those records not pertaining to a particular individual coming within the jurisdiction of this Board may be released at the discretion of the Chairman with the concurrence of a majority of this Board.

#### ARTICLE VII. AMENDMENTS TO BY-LAWS

These by-laws may be amended by an affirmative vote of four (4) members present at any annual meeting or any special meeting called for the purpose of amending these by-laws.

#### ARTICLE VIII. FISCAL YEAR

The fiscal year of this organization shall begin on the first day of July and end on the last day of June.

#### ARTICLE IX. PROCEDURE

The rules set forth in the latest edition of Robert's Rules of Order shall govern the conduct of the affairs of this organization, unless such rules are inconsistent with these by-laws or with a rule adopted by the Board.



THOMAS L. RUDGE  
GOVERNOR

State of Montana  
Office of The Governor  
Helena 59601

JAN 23 1976

January 19, 1976

Mr. William Conyard, Superintendent  
Boulder River School and Hospital  
Boulder, Montana

Dear Mr. Conyard,

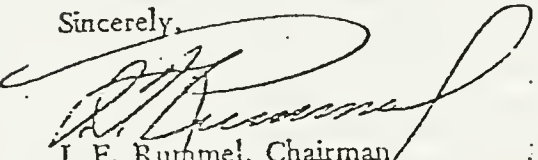
The Mental Disabilities Board of Visitors wants to thank you for the well planned and conducted orientation visit last week. We intend to prepare a policy and procedures manual as soon as possible and the visit was invaluable to this end.

We made one observation which requires immediate action on your part. Please accept this as a recommendation of the strongest nature.

The cottages need immediate and continual cleaning. This includes the grounds - specifically the "yard" around cottages 4 and 5. Please advise the board of your actions and results. All of this constitutes a policy and procedure the board is anticipating. In other words we will appraise facility directors of problems for corrective action before taking formal action.

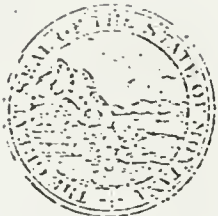
For ease of communications please address correspondence to Dr. Hamerlynck.

Sincerely,

  
J. F. Rummel, Chairman  
Mental Disabilities Board of Visitors

APPENDIX 3--B

LETTER TO BOARD OF VISITORS FROM BRS&H



# Boulder River School and Hospital

BOULDER, MONTANA 59632

THOMAS L. JUDGE  
GOVERNOR

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WILLIAM F. CONYARD  
SUPERINTENDENT

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\*\*\*\*\*  
\*\*\*\*\*  
ROBERT H. MATTSON  
DEPT. OF INSTITUTIONS

January 30, 1976

Dr. Leo Hamerlynck  
Mental Health Disabilities Board of Directors  
Office of the Governor  
Capitol Station  
Helena, Montana 59601

Dear Dr. Hamerlynck:

In response to Dr. Rummel's letter of January 19, 1976 recommending immediate and continual cleaning of the cottages and surrounding areas, I am prepared to take the following actions to alleviate the undesirable conditions:

1. On a weekly basis, with weather permitting, grounds-keeping crews will attend to areas immediately surrounding all cottages and remove the debris which has been accumulated. Cottage staff will be held responsible for collecting articles of clothing and linen which have been left out of doors.
2. In addition to the regular cottage housekeeping staff, a central house-keeping team has been formed. This team is responsible for heavy, thorough cleaning of the cottages (e.g., stripping and waxing of floors, washing walls, etc.) and will serve all cottages on a rotating basis. Each cottage will be cleaned by this team at least once a month with those cottages housing lower functioning residents being cleaned more frequently. The regular cottage housekeeping staff will continue to be responsible for the daily routine tasks such as mopping floors and cleaning bathrooms.
3. A committee has been formed to investigate the possibility of initiating an incentive system such as offering a Housekeeping Award to the cottage maintaining the highest level of cleanliness each month. It has been proposed that this award be in the form of a cash prize to be used for the benefit of the residents of the cottage (e.g., party, purchase of records).

Attempts will be made to continually monitor the effectiveness of each of these programs and make changes as needed to maximize the intended results. Simultaneously, an intensive effort will be made to address the problem from a programmatic standpoint. The majority of the unacceptable conditions you

viewed cannot be eliminated as long as the behaviors of the residents are unaltered. Until such a time as the maladaptive and inappropriate behaviors are dealt with through training, the cottages will appear unkept and unsanitary unless total staff effort is directed toward housekeeping rather than training. Boulder River School and Hospital has as its goal treatment and habilitation for all residents and at the present time planning sessions are directed toward the achievement of this goal in the most efficient manner possible. However, it is not the intent of the Administration to sacrifice a sanitary environment for the sake of training and I assure you that you will notice a significant improvement on your next visit to Boulder.

Sincerely yours,

*William F. Conyard*  
William F. Conyard  
Superintendent

cc: Tom Dolan  
Richard Heard

bs

APPENDIX 4-A

REPORT OF DR. HARR ON WSSH



April 28, 1976

CONFIDENTIAL

Mental Disabilities Board of Visitors  
State of Montana  
c/o Dr. L. A. Hamerlynck  
Governor's Office  
Capitol Building  
Helena, Montana 59601

Dear Sirs:

The Mental Disabilities Board of Visitors made an inspection visit to the Warm Springs State Hospital on January 15, 1976, and to the Boulder River School and Hospital on January 16, 1976. The purpose of this visit was to gain overall awareness of the facilities involved as mental health facilities in the State of Montana, and in addition to that to develop some awareness as to whether appropriate treatment plans were present for individual patients, as well as adequate facilities for carrying out these plans.

At the Warm Springs State Hospital two different treatment units were selected at random to be visited in the morning without any advance notice to these units. In those locations I had the opportunity of interviewing both nurses and psychiatric aides to determine their attitudes and viewpoints regarding the treatment approaches, and in addition to that I inspected the treatment plan of several different patients picked somewhat at random. I also had the opportunity of talking individually with some of the patients involved in the treatment programs, in order to obtain a direct impression of the attitudes of these patients in regard to the hospitalization and individual treatment program for each respective patient. In the afternoon two other units were visited in company with the Mental Disabilities Board of Visitors, at which time there also was an opportunity to speak with patients individually as well as to look at the individual treatment plans of a few patients.

It was my impression from this relatively cursory visit that the most active programs currently are in the Geriatric Unit and in the Forensic Unit. Treatment plans appeared to be individualized to each patient's own condition and circumstances, and I was particularly impressed with the degree of enthusiasm evident in the staff forming the treatment teams. An in-service training program with the staff in the Geriatric Unit has produced an enthusiastic response to the current approaches toward reality therapy for those patients, and yet at the same time there seemingly is an acceptance of realistic goals for the individual patients. I also noted that there appeared to be suitable treatment orders present for the physical needs of those patients. In the Forensic Unit there are numerous logistic problems in regard to treating patients in that setting, but it was my

April 28, 1976

impression that the patients were more dissatisfied with their location than they were with any problems dealing with the actual treatment plan itself. The staff in this Unit was particularly knowledgeable and alert, and appeared to be quite well aware of each patient on an individual basis. Rather thorough individualized treatment plans have been worked out for each patient on this Unit. The security measures in this Unit are so extensive that treatment activities are necessarily limited, but I did not find any indication of a patient being neglected in regard to a treatment approach.

On the other two units the visits were made at a later time in the day when there was less activity evident on the wards, but there was an equal degree of enthusiasm in the staff members present regarding the current method of individualized treatment plans. It was difficult to determine just how much each patient is involved in treatment activities, although the relatively few patients with whom I talked were generally aware of a treatment program for himself or herself. The physical environment in these two wards was much improved over what it had been in past years, but it was quite evident that room for further improvement was prevalent. To a certain degree there perhaps is a paradox between individualized treatment plan and the general arrangement of the wards and the furniture placed in these wards, with the latter tending to interfere with an individualized approach and with the more independent self-realization of the patients themselves. This was particularly evident in one unit where the television was noted to be on a relatively high volume of sound, which one might question in regard to how much interference this plays in developing individualized interpersonal reactions and relationships which are a part of an individualized treatment plan.

All in all the improvements at the Warm Springs State Hospital in regard to treatment plans, staff attitudes, and physical surroundings were enlightening and enheartening. It was my impression that this institution should be commended for the significant changes that have been carried out or at least initiated in the last few months which more adequately meet the needs for a therapeutic program for patients and also which at the same time comply with the requirements of the new mental health act. It is my impression that leadership for this treatment program will be further developed on an individualized basis as each separate treatment unit is able to have a qualified psychiatrist directly in charge of that particular unit rather than some of the psychiatrists needing to supervise more than one unit. Although this arrangement will allow for each unit to function somewhat independently for the therapeutic community approach, it will remain important for the clinical director to further develop a program for educational and peer review activities among the

Mental Disabilities Board of Visitors  
c/o Dr. L. A. Hamerlynck  
Helena, Montana 59601

Page 3

April 28, 1976

psychiatrists on the staff of the Warm Springs State Hospital. Both the psychiatrists and the non-psychiatrist physicians would benefit from having the latter involved in this same program. Supervision of the care and treatment of this number of patients is an extensive activity to say the least, and the opportunity for continuing education programs among the staff members and also with occasional outside professional persons will be to the benefit of all involved.

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At the Boulder River Hospital only the hospital and pharmacy were visited. The latter is well organized. On the various units of the hospital, activities were being conducted both with individuals and groups. Apparently each patient was being considered individually for treatment approach, but there was not sufficient time to adequately evaluate this. No problems were noted in the attitudes of regular or volunteer staff toward the patients.

Respectfully submitted,

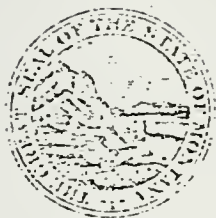


Donald L. Harr, M. D.

DLH:vm

APPENDIX 4-B

LETTERS SUPPORTING LEGAL ASSISTANCE FOR INSTITUTIONS



State of Montana  
Office of The Governor  
Helena 59601

THOMAS L. JUDGE  
GOVERNOR

March 1, 1976

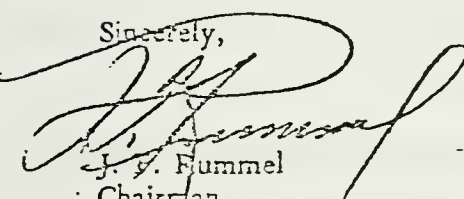
Dr. R. H. Mattson  
Department of Institutions  
Helena, MT 59601

Dear Bob,

The Mental Disabilities Board of Visitors has detected what it considers a serious problem at Warm Springs State Hospital and Boulder River School and Hospital. More than likely the problem has correlated issues within the communities. Consequently we are asking your assistance. It is our opinion that the institutions do not have the legal counsel needed to fulfill the conditions of SB 388 and SB 377. Attached is a memo from one of our consultants on the problem and possible courses of action.

The board has assumed considerable responsibility for a program of Professional and Public Education. However, we do not feel that it is within our jurisdiction to take action on this problem. Please advise us if there is anything we might do to assist. The problem is doubly significant in that the law does not permit the board to allow for deficiencies in any manner. Thus, we may observe a deficiency which has a reasonable explanation but we have no latitude except take formal action.

Sincerely,

  
J. V. Fummel  
Chairman



To: Leo A. Hanerlynk

From: Rosemary B. Zion

Re: Implementation of S.B. 377 and S.B. 383 at WSSH and BRSH

As a result of our meetings on January 15 and 16 of this year with the staff at Warm Springs State Hospital and Boulder River School and Hospital, I am very concerned about the need for both institutions to have available legal advice and assistance on a day to day basis. Especially during the period while these new laws are first being implemented, and while rules and procedures are being designed it is extremely important that both institutions work very closely with an attorney to make sure that they are complying with the law.

I was concerned with a number of comments that were made at both institutions. The staff indicated that there are procedures which in their professional opinion they should follow but which they are hesitant to follow because they do not know if they would be in conflict with the law. I am convinced that the two acts permit the full range of legitimate professional alternatives. It is distressing to think that treatment or habilitation alternatives may be by-passed because the staff is uncertain of the law.

There appears to be a need to improve coordination with the district courts in the implementation of the laws. An attorney on the scene who can speak the language both of the professionals at the institutions and the judges and county attorneys could do a great deal to help create smoother procedures and better cooperation between the groups.

Staff at both institutions need help in the area of renewal of commitment. They need to be sure what is required of them in the renewal process. They also need some immediate help in properly discharging residents and in setting up conditional release procedures. There is a particular need for assistance in coordinating their efforts with the other groups and agencies involved in the community placement process. Perhaps a contract or mutually arrived at agreement



as to procedures and responsibilities could help in this area.

There is a critical need to develop rules and policies within the institutions in those areas where the rights of residents and patients on the one hand and the treatment and habilitation programs being implemented by the staff intersect. For instance, policies should be developed for handling money of residents. Standards for determining compensation for resident labor should be developed. Standards should be established for behavior modification programs, particularly where these programs involve temporary suspension of a right or withdrawal of a privilege. It seems to me that the behavior modification programs being used are legitimate and within the law. But I would feel more at ease if the policies involved were spelled out and if procedures were developed to assure accountability.

S.B. 377 and 388 have put in statutory form the rights of residents of both institutions. This means that in case of abuse of those rights, residents have a remedy both under the Constitution and under the statutes. Careful implementation of the statutes should protect the institutions from Constitutional attacks on their procedures. However failure to implement the two acts could make a legal attack on the two institutions all the easier to maintain.

I realize that the Department of Institutions does have an attorney. However, the kind of legal assistance I am advising, particularly in this initial period, would totally absorb the efforts of an attorney. It is difficult to see how the rest of the work of the department could be adequately covered and this project too. I very much hope that some arrangement can be worked out to give these two institutions the help they so critically need.

APPENDIX 4-C

VITA

Dr. John M. Atthowe

ATTHOME, John M., Jr.

Born: March 8, 1924, San Francisco, California

Married: Two Children: Helen, 4/12/59 and John, 11/9/61

I. Education and Training

A. Undergraduate training:

1. University of California (Berkeley), 1941-42 and 1948-50; A.B., 1950 (Psychology).

B. Graduate training:

1. University of Oregon, 1950-52; M.S. with honors, 1952 (Experimental Psychology).
2. Stanford University, 1952-55; Ph.D. (Personality, Social and Learning).

C. Post-doctoral training:

1. Stanford University and the V.A. Hospital, Palo Alto, California, 1962-63 (Clinical internship).

II. Professional Experience

A. Teaching

1. Instructor, Psychology
  - a. University of Maryland (Overseas program - Europe), 1955-57.
  - b. Emory University, 1957-58.
2. Assistant and Associate Professor, Psychology
  - a. University of Alabama, 1958-63.

B. Teaching and Clinical Supervision

1. Professor and Chairman, Department of Psychology, College of San Mateo, 1965-69.
2. Professor, Psychology and Psychiatry
  - a. University of Montana, 1969-1972.
  - b. Rutgers Medical School and Rutgers University, 1972 - Present

C. Clinical

1. Research Associate in Psychology, V.A. Hospital, Palo Alto, 1963-65
2. Counselor (Part-time), College of San Mateo, 1965-67.
3. Supervisory Psychologist (Part-time), V.A. Hospital, Palo Alto, 1967-69.
4. Private Practice, 1964 - Present.

D. Administration

1. Director, Behavioral Modification Unit, V.A. Hospital, Palo Alto, 1963-65.
2. Chairman, Department of Psychology, College of San Mateo, 1965-69.
3. Director, Assessment and Evaluation, V.A. Hospital, Palo Alto, 1966
4. Director, Quality Assurance Service (Program Evaluation, Management Information Systems, Medical Records), Rutgers Comprehensive Community Mental Health Center, Rutgers Medical School, 1972 - Present

III. Professional and Honorary Societies, Professional Certification and Honors:

A. Professional Societies

1. American Psychological Association
2. Regional Psychological Association
3. Association for the Advancement of Behavior Therapy
4. American Association for the Advancement of Science

- B. Biographical listing in: (1) American Men and Women of Science: Social and Behavioral Sciences; (2) American Men and Women of Science: Urban Community Sciences; (3) American Men and Women of Science: The Medical Sciences; (4) Leaders in American Education; (5) Leaders in American Science; (6) Who's Who in American Education; (7) Who's Who in the Biological Sciences; (8) Who's Who in the West; (9) Who's Who in the East; (10) Community Leaders of America; (11) Community Leaders and Noteworthy Americans; (12) The National Register of Prominent Americans and International Notables; (13) International Scholars Directory; (14) Dictionary of International Biography and Creative and Successful Personalities of the World; (15) Personalities of the West and Midwest; (16) Contemporary Authors.

C. Certification and Licensing:

1. State of Montana (Psychology) (no longer operative)
2. State of New Jersey (Psychology). No 1056.
3. Charter Clinical Fellow of the Behavior Therapy and Research Society

D. Honors

1. Honors program in psychology, University of California 1949-50.
2. Sigma Xi, 1951.
3. M.S. with honors, University of Oregon, 1952.
4. Elected representative at large, Association for Advancement of Behavior Therapy.

IV. Teaching Experience:

- A. Taught and developed undergraduate and graduate courses in general - experimental and clinical psychology.
- B. Speciality: Behavior Modification (contingency management and environmental engineering): Community Mental Health; Accountability (Ethics, Patients Rights, Goal-Oriented Medical Records, Program Evaluation and Outcome Studies).
- C. Taught and developed continuing education workshops and paraprofessional courses in psychology, behavior modification and mental health.
- D. Taught and developed practicum training programs in clinical psychology and in School of Professional Psychology
- E. Given workshops to professionals and paraprofessionals on Behavior Modification and Problem Oriented Medical Records.

V. Consultant and Advisory Experience:

- A. (1) Consultant to State and Veterans Hospitals (Arizona, West Virginia, and Alabama State Hospitals and V.A. Hospitals, Palo Alto, Lyons and Tuscaloosa); (2) to Mentally Retarded Hospital (Boulder, Montana); (3) to State Prison (Montana); (4) to extended Care Facilities (Chronic Illness in San Mateo County Public Health and Welfare Dept.); (5) to Residential and Work Rehabilitation Programs (Veterans Workshop, Inc., Menlo Park, Calif. and Addiction, Rehabilitation Center, Missoula, Mt.); (6) to Head Start Programs (Western Montana and Indian Reservations); (7) to Assessment and Remediation Programs for Learning Disabilities and Problem Behavior (School District, Missoula, Mt.); (8) to Crisis Center, Youth Emergency Service and Open-Door Clinic (Missoula, Mt.); (9) to Department of Mental Hygiene (Alabama); (10) to Peace Corps.
- B. Advisory Board or Board of Directors: Veterans Workshop, Inc., Missoula Crisis Center; Western Montana Council of Alcoholism and Other Drug Dependency; Montana Association of Mental Health; Behavior Therapy Institute (Sausalito, Calif.). Association for the Advancement of Behavior Therapy. Institute for Behavior Therapy, New York City.
- C. Consulting editor: Psychological Reports; Behavior Therapy, Journal of Consulting and Clinical Psychology; Journal of Applied Behavior Analysis; American Psychologist. Editorial Board, Behavior Therapy.



## VI. Research Experience:

- A. Treatment and assessment of psychiatric patients - Veterans Administration Research Associate Grants, 1963-65 and NIMH Grant to Dr. L. Krasner, 1962-65.
- B. Hypnotic scaling - USPHS Grant to Stanford University (Dr. E. R. Hilgard), 1962-63.
- C. Description and evaluation of chronic illness - USPHS Grants to Department of Public Health & Welfare, San Mateo County, Ca., 1963-67.
- D. Verbal conditioning -- Research Grant, Alabama Department of Mental Hygiene, 1961-62 and NIMH Grant to Stanford University (Dr. L. Krasner), 1962-63.
- E. Operant decision making: An analysis of strategy - University of Alabama Research Grant with the assistance of the Alabama State Hospitals, 1960-62.
- F. Measurement of values: Utility and subjective probability - Ford Foundation Grant to Stanford University (Dr. D. Davidson & P. Suppes), 1963-65.
- G. Other special areas of research: Token economics, enuresis, self-reinforcement and self-evaluation, techniques of behavior therapy, the outcome of treatment, goal oriented medical records, community influence on mental health and the impact of mental health programs on the community.

## VII. Publications and Papers

### A. Books, Chapters, Monographs:

1. Atthowe, J. M., Jr. and Siegel, S. Decision making and conflict theory: Approach-avoidance gradients. Pennsylvania State University Studies In Psychology, No. 14, University Park, Pa.: Penn State Press, 1961. 20 pp.
2. Salmon, P., Atthowe, J. M., Jr., and Hallock, M. R. Rapids: A method for classifying patients receiving long-term care. San Mateo, Ca.: Dept. of Public Health and Welfare, 1966. 66pp.
3. Salmon, P., Atthowe, J. M., Jr., and Hallock, M. R. Rapids: Part II: A comparison of needs and resources. San Mateo, Ca.: Dept. of Public Health and Welfare, 1967. 50 pp.
4. Atthowe, J. M., Jr. Understanding man. Belmont, Ca.: Peninsula Offset Service, 1969. 70 pp.
5. Krasner, L. and Atthowe, J. M., Jr. The token economy as a rehabilitative procedure in a mental hospital setting. In Rickard H. C. (Ed.), Behavioral interventions in human problems. New York: Pergamon, 1971. Pp. 311-334.
6. Atthowe, J. M., Jr. Behavioral innovation: An all-encompassing system of intervention. In Harschbarger, D. and Malay, R. F. (Eds.), Behavior Analysis and Systems Analysis: An Integrative Approach to Mental Health Programs. Kalamazoo, Mich.: Behaviordelta, Inc. 1974. Pp. 168-193.
7. Atthowe, J. M., Jr. Nocturnal enuresis and behavior therapy: A functional analysis. In Rubin, R. D., Fensterheim, H., Liberman, R. P., and Wilder, S. N. (Eds.), Advances in behavior therapy. New York: Academic Press, 1973. Pp. 263-271.
8. Messer, S. B., Atthowe, J. M., Jr., et.al. Treatment of Psychological disorders. In Miller, B. (Ed.), Reference encyclopedia of mental health. Philadelphia, Pa.: North American. In Press.

10. Atthowe, J. M., Jr., and Krasner, L. In Coldstein, A. P., and Stein, N. Prescriptive Psychotherapies. New York: Pergamon, In Press.
  11. Atthowe, J. M., Jr. In XIP Readings in Psychology, Lexington, Mass.: Xerox College Publishing, 1974.
  12. Atthowe, J. M., Jr. Controlling nocturnal enuresis in the severely disabled. In Franks, C. M., and Wilson, G. T. (Eds.), Annual review of behavior therapy. New York: Brunner/Mazel, 1973. Pp. 572-579.
  13. Atthowe, J. M., Jr. Controlling nocturnal enuresis in the severely disabled. In Katz, R. C., and Zlutnick, S. (Eds.), Behavior Therapy and Health Care, New York: Pergamon, 1974. Pp. 95-100.
  14. Atthowe, J. M., Jr. Behavior innovation and persistence. In Eckensberger, D. (Ed.), Gruppendynamik: Forschung und praxis. Stuttgart: Ernst Klett Verlag, 1973. Pp. 84-97.
  15. Atthowe, J. M., Jr. Behavior innovation and persistence. In McReynolds, W. T. (Ed.), Behavior therapy in review. New York: Aronson, In Press.
  16. Atthowe, J. M., Jr. Behavior innovation and persistence, In Franks, C. M., and Wilson, G. T. (Eds.), Annual review of behavior therapy. New York: Brunner/Mazel, 1974. Pp. 431-444.
  17. Atthowe, J. M., Jr. In XIP Readings in Psychology. Lexington, Mass.: Xerox College Publishing, 1974.
- C. Articles, book reviews and abstracts:
1. Atthowe, J. M., Jr. Decision making and conflict. American Psychologist, 1958, 13, 360 (Abstract).
  2. Atthowe, J. M., Jr. Monadic and dyadic studies of decision-making and conflict resolution. Unpublished doctoral dissertation, Stanford Univ. Library. Stanford Univ., Stanford, Ca., 1958. In dissertation abstracts 19, 3008-3009, 1959.
  3. Atthowe, J. M., Jr. The process of interpersonal influence: Influence transmission and development. American Psychologist, 1959, 14, 382 (Abstract).
  4. Atthowe, J. M., Jr. Types of conflict and their resolution: A reinterpretation. Journal of Experimental Psychology, 1960, 59, 1-9.
  5. Atthowe, J. M., Jr. Interpersonal decision making: The resolution of a dyadic conflict. Journal of Abnormal and Social Psychology, 1961, 62, 114-119.
  6. Atthowe, J. M., Jr., and Krasner, L. The systematic application of contingent reinforcement procedures (Token Economy) in a large social setting: A psychiatric ward. American Psychologist, 1965, 20, 591 (Abstract).
  7. Atthowe, J. M., Jr., and Krasner, L. A preliminary report on the application of contingent reinforcement procedures (Token Economy) on a "chronic" psychiatric ward. Journal of Abnormal Psychology, 1968, 73, 37-43.
  8. Atthowe, J. M., Jr. Behavior modification and the community rehabilitation of psychiatric patients. Hospital and Community Psychiatry, 1968, 19, 61-63.
  9. Atthowe, J. M., Jr. Experimental social innovation: Shaping the social system, Newsletter for research in Psychology. V.A. Center, Hampton, Va., 1969, 11, 39-41.
  10. Atthowe, J. M., Jr. Controlling nocturnal enuresis in the severely disabled. Behavior Therapy, 1972, 3, 232-239.



11. Atthowe, J. M., Jr. Behavior innovation and persistence. American Psychologist, 1973, 28, 34-41.
12. Atthowe, J. M., Jr. Token economies come of age. Behavior Therapy 1973, 4, 646-654.
13. Molineux, J. B., and Atthowe, J. M., Jr. Self-rewarding and self-punishing behavior in mildly depressed college students. Behavior Therapy, In Press.
14. Atthowe, J. M., Jr. Behavior innovation and persistence. Modifying already established social systems, Psychiatric Quarterly, In Press.
15. Atthowe, J. M., Jr.; Malott, R. W. Humanistic Behaviorism and Social Psychology. Book Review in Behavior Therapy, 1974, 5, 594.
16. Atthowe, J. M., Jr.; Freedman, A. E. The Planned Society: An analysis of Skinner's proposals. Book Review in Behavior Therapy 1974, 5, 714.

D. Tests and Films

1. Atthowe, J. M., Jr., and McDonough, J. To save tomorrow: Operative re-entry. NET-TV documentary film. Produced by WTTV Chicago and the Social and Rehabilitation Services, HEW, Washington, D. C., 1969. (Project chosen as 1 of 7 innovative project in USA). Now distributed by Audiovisual Center, Indiana Univ.; Bloomington, Ind.
2. Atthowe, J. M., Jr. Understanding man. NET-TV film series (31 programs) for general psychology. Produced and distributed by KCSM-TV, San Mateo, Ca., 1969.
3. Atthowe, J. M., Jr. Patient performance inventory (PPI), V.A. Hospital, Palo Alto, Ca., 1968.
4. Atthowe, J. M., Jr. The behavioral inventory for hospitalized psychiatric patients, Rev. Ed., 1965, V.A. Hospital, Palo Alto, Ca., V.A. Form 10-87 (5024).
5. Atthowe, J. M., Jr. Standard interview (Minimal behavior scale). V.A. Hospital, Palo Alto, Ca., 1964.
6. Atthowe, J. M., Jr.; Hallock, M., and Salmon, P. The RAPIDS profile for describing chronic illness, Form E: Actual effort expended. Rev. Ed., Dept. of Public Health and Welfare, San Mateo County, Ca., 1965.
7. Atthowe, J. M., Jr.; Hallock, M., and Salmon, P. The RAPIDS profile for describing chronic illness, Form N: The needs of the patient. Dept. of Public Health and Welfare, San Mateo County, Ca., 1966.

E. Unpublished Bibliographies and Manuals

1. Krasner, L., Atthowe, J. M., Jr., and Silva, H. J. Token economy bibliography, 2nd Ed., Psychology department, SUNY at Stony Brook, L.I., N.Y., 1969.
2. Krasner, L., and Atthowe, J. M., Jr. Token economy bibliography. Psychology department, SUNY at Stony Brook, L.I., N.Y., 1968.
3. Atthowe, J. M., Jr. Ward 113 research and service program: Staff orientation and procedure manual for administering the token-incentive program. V.A. Hospital, Palo Alto, Ca., 1964.
4. Atthowe, J. M., Jr. A manual for relaxation training, Rev. Ed., Clinical psychology center, University of Montana, Missoula, Mt., 1972.

F. Papers

1. Presentation of over 50 papers at Meetings and Conferences on behavior modification and behavior therapy, conflict and utility theory, community mental health, accountability and medical record and ethical and legal issues.

17. Atthowe, J. M., Jr. *Behavior modification, behavior*

# VIII. In Preparation

## A. Books

1. Atthowe, J. M., Jr., and Braun, S. (Eds.), Legal and Ethical Issues in Behavioral and Social Control.
2. Atthowe, J. M., Jr. Accountability and Therapeutic Intervention.
3. Atthowe, J. M., Jr. Understanding Mental Health.

## B. Chapters in Book

1. Writing a chapter on Behavior Therapy and Social Systems in Potentials for Personal Enrichment to be edited by Donald Klein and Allen Feinstein.

## C. Articles

1. Atthowe, J. M., Jr. Accountability and Ethics.
2. Johnson, W. G., Pollack, I. W., and Atthowe, J. M., Jr. Cost effectiveness and chronicity.
3. Atthowe, J. M., Jr., Pollack, I. W., and Johnson, W. G. Keeping mental patients in the community.

## D. Work

1. Helping to develop a Comprehensive Community Mental Health Center as part of the Department of Psychiatry of the Rutgers Medical School. Of special concern: (a) Developing a clinical and administrative computerized medical record system, (b) Developing a goal-oriented medical record system, (c) Developing an outcome and program evaluation program.
2. Helping to develop a School of Professional and Applied Psychology (Rutgers University and Rutgers Medical School).

APPENDIX 4-D

VITA

Dr. John M. Rochford

# CURRICULUM VITAE

## PERSONAL DATA

1. Born October 14, 1943 - New York, New York
2. Married February, 1974, to Barbara Ulricksen

## EDUCATION

1. B.A., New York University, Honors in Chemistry - 1965
2. M.D., Yale University Medical School - 1969

## INTERNSHIP

1. Georgetown University Medical Service, Washington VA Hospital

## RESIDENCY

1. Psychiatric residency, University of Pennsylvania, School of Medicine  
1970-1973

## STATE LICENSES HELD

1. Pennsylvania - 1970
2. New Jersey - 1973
3. California - 1975

## BOARD CERTIFICATION

1. American Board of Psychiatry and Neurology - Certification in May, 1975

## MILITARY SERVICE

1. Captain, United States Army Medical Corp - 1972 - Present

## ACADEMIC APPOINTMENTS

1. Assistant Professor of Psychiatry  
Rutgers Medical School - July 1973 - Present

## HOSPITAL APPOINTMENTS

1. Consultant in Psychiatry, Raritan Valley Hospital - July 1973 - Present

## CAREER

1. Director, Acute Psychiatric Service, Rutgers Community Mental Health Center - February 1974 - Present

## FACULTY

1. Chairman of the Ad Hoc Committee on the Future of the Department of Psychiatry
2. Chairman of the Medical Audit Committee

## TEACHING

1. Administrative
  - A. Member of Curriculum Committee which is responsible for the organization of the medical students' teaching program
  - B. Chairman of Subcommittee on Introduction to Clinical Psychiatry  
Responsible for organizing lecture series, seminars and clinical interviewing.
  - C. Member of Doctorate Committee of one student from the Graduate School of Psychology
  - D. Director of the following courses for psychiatric residents:
    1. Psychopharmacology
    2. Crisis Intervention
    3. Behavior Therapy
    4. Schizophrenia
2. Clinical
  - A. Supervision and training of residents in psychotherapy, chemotherapy and emergency psychiatry
  - B. Supervision of medical students in the second year interviewing course and third year psychiatry clerkship
  - C. Supervision of one student from the Graduate School of Psychology
3. Didactic
  - A. Lecturer in Behavioral Sciences Course for Medical Students on Neuropsychopharmacology and in Mini Course on "Use of Marijuana and Hallucinogenic Drugs"
  - B. Lecturer in Introduction to Clinical Psychiatry Course on Clinical Psychopathology and Schizophrenia

## RESEARCH

1. The Glucose Tolerance Test. Insulin Tolerance Test and Growth Hormone Response in Depressive Syndromes Treated with Tricyclic Antidepressants or ECT. (Swartzburg, Rockford, Mueller)
2. The Glucose Tolerance Test and Insulin Tolerance Test in Occult Cervical Carcinoma - Before and After Surgical Treatment. (Mueller, Chowdrey, Rockford, Swartzburg)
3. Investigation of Insulin Tolerance Test and Thermoregulation in obese patient before and after jejunal bypass procedure
4. Investigation of EEG Hemispheric Laterality and Skin Conductance in Patients with Schizophrenia and Affective Disorders

## PUBLICATIONS

1. Neuropsychological Impairments in Functional Psychiatric Diseases. Rochford, Detre, Tucker et al. Archives of General Psychiatry, February 1970
2. Neuropsychological Assessment of the Effects of Moderate Marijuana Use. Grant, Rochford, Fleming et al. Journal of Nervous and Mental Disease, 1973
3. Medical Students and Drugs - Further Neuropsychological and Use Pattern Considerations. Rochford, Grant, LaVigne (Accepted for publication in the International Journal of the Addictions)
4. Abbot 38579 (Synthetic TRH) in the treatment of Depression: A Controlled Study of Oral Administration. Sugerman, Mueller, Swartzburg, Rochford. Psychopharmacology Bulletin 1975 Vol 11, page 30 (abstract)
5. Oral protirelin (TRH) in depression. Sugerman, Swartzburg, Mueller, Rochford. Curr. Therap. Res. 1976 Vol. 19, Pgs. 94-98.
6. Some Quantitative EEG Correlates of Psychopathology. Rochford, Swartzburg, Chowdhrey, Goldstein. Research Communications in Psychiatry, Physiology and Behavior.



APPENDIX 4-E

REVIEW OF WSSH FOR THE BOARD OF VISITORS

Dr. John M. Atthowe

Dr. Joseph M. Rochford

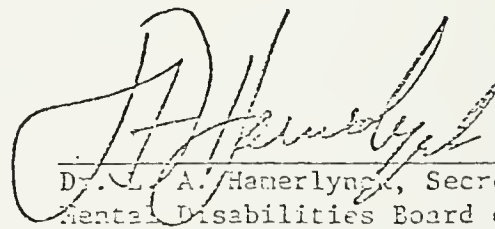
Confidential  
Report

REVIEW OF  
WARM SPRINGS STATE HOSPITAL  
FOR THE  
BOARD OF VISITORS

John M. Atthowe, Jr., Ph.D.  
Professor of Psychiatry, and  
Director of Quality Assurance Services  
Rutgers Medical School

Joseph M. Rochford, M.D.  
Assistant Professor of Psychiatry, and  
Director of Acute Psychiatric Services  
Rutgers Medical School

As a member of the Mental Disabilities Board of Visitors I concur  
with the findings and recommendations contained in this document. I acted  
as chairman of the survey team.



Dr. L. A. Hamerlynck, Secretary  
Mental Disabilities Board of Visitors

April 30, 1976

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  - C. Patient Rights and Privacy
- IV. Staffing Patterns
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REVIEW OF WARM SPRINGS  
STATE HOSPITAL FOR THE  
BOARD OF VISITORS

I. INTRODUCTION

The delivery of mental health services is experiencing a renewed scrutiny. Mental health professionals are now asking and being asked why and how they are delivering services. The new concern in mental health is accountability and all indications are that this concern will intensify.

Many points of pressure have converged upon the delivery of human services in recent years to make them more accountable. The Federal Government, through its dispensing of money in grants, and the creation of health insurance programs have focused attention upon the rights of patients, especially the right to adequate treatment, and standards for the delivery of care. The Professional Standard Review Organizations (PSRO) have been mandated by Congress to establish standards of care and to review the treatment funded by Federal programs and grants. Such an organization will soon be in operation in Montana. However, no Federal funds will be dispensed to a mental health facility unless that facility is approved by the Joint Commission on Accreditation of Hospitals (JCAH). JCAH not only will review the adequacy of patient care, but they will also review the physical facilities and administrative procedures.

In the past ten years the courts have begun to define the rights of mental patients, especially the right to receive adequate and effective treatment. State legislatures have begun to introduce laws designed to carry out these ideas.

The courts in the historical Wyatt v. Stickney case stated that there are three fundamental conditions for effective and adequate treatment: (1) a

humane physical and psychological environment; (2) a qualified staff in numbers sufficient to administer adequate treatment; and (3) an individualized treatment plan.

The responsible professional person must take whatever action he feels is best for his patient. However, it is the responsibility of the professional person to document what actions were taken and why. Both peer and judicial review look for reasonable but documented treatment plans. Therefore, the major source for determining adequate patient care is the patient's medical record, especially the individualized treatment plan.

Our review of Warm Springs State Hospital focuses primarily on patients' records and secondarily on the physical and psychological environment, on staffing and on administrative procedures.

## II MEDICAL RECORDS

Our review of medical records involved the administration of the medical records, the adequacy of the records, especially the treatment plans, and the medications prescribed.

### A. Medical Records Procedures.

The medical records, especially those records prior to 1976, were generally poorly organized and incomplete. Part of this problem is a result of not having a qualified person in charge of medical records. Indexes and basic statistical information, such as discharge diagnoses, duration of treatment and length of stay by diagnoses should be maintained by the medical records or statistical unit. Such information is not only necessary for an adequate utilization and review of patient care, but also is required by JCAH.

According to JCAH Accreditation Manual, "A qualified medical record librarian or an accredited record technician should be employed on either a full-time or part-time basis, . . . When the facility does not employ such a person,

1. In general our results indicated the presence of adequate identifying information and good social histories. Psychological evaluation when done was more than adequate. Physical examinations were missing in 8 out of the 19 records examined. (This could be due to slow processing in the medical records room and keeping some records on the patient's ward, although two patients who were discharged had no physical examinations in their charts.) Most charts had records of a urinalysis although two did not. In a spot check of whether a urinalysis and CBC was found in ward records only one of eight records were deficient.

2. Consent forms were found in all records; however the consent and release of information forms might be reevaluated, especially in light of the contractual arrangements with local mental health centers. Consent for evaluation and routine treatment is more often completed prior to the arrival of the patient. The new commitment procedures were often not followed out (although these are very new proceedings). The consequence is still a tendency to inappropriately "dump" patients, especially by Sheriffs' Offices onto the hospitals.

3. Adequate individualized treatment plans were missing in most patients' records. An adequate treatment plan includes the initial treatment plan and later modifications. Adequate initial treatment plans were found in ten of nineteen records but subsequent modifications and justification for the treatment modality administered as well as justification for the diagnosis made were not readily ascertainable. Too much of the professional staff's thinking remains implicit.

According to Senate Bill 377, each treatment should include: (a) a statement of the patient's specific problems and needs - only two of nineteen records had a description of problems that could be treated. These two descriptions were by student nurses and were couched in problem oriented medical record terminology and appeared in the nursing care plans not in the treatment plan. It is



recommended that the nursing care plans be incorporated with the individualized treatment plans and that a problem oriented format be followed. (b) Long-term and short term goals were spelled out in six of nineteen and ten of nineteen records. These records contained a new treatment plan form which incorporates the regulations in Senate Bill 377. However the relationship of goals to problems or diagnoses or to treatment modality were implicit rather than indicated. Only three of nineteen records had any stated time table for attaining their goals. (C) Every record except three specified some treatment modality. Most records indicated that the patient involved would receive group psychotherapy, medication, and activity therapy irrespective of the patient's problem or diagnosis. The selection of a mode of treatment was so general that it turned out to be the same regardless of the patient's goals. The treatment plans points up our lack of knowledge in treating mental illness. However, public law 377, the model criteria proposed for PSRO's and the JCAH manual specify that each record be specific and accountable. Biological intervention (e.g., medications) fits this model, but social and psychological therapy is hard to fit within such a model. Therefore, we recommend that the professional staff receive training in the problem oriented medical record, possibly from the same person or persons who are teaching the student nurses in writing nurses care plans. When the University of Washington residents come to Warm Springs this might be one of the first priorities for in-service training programs. We have included some suggestions in this regard in Appendix C. (d) In not one of the records was staff responsibility specified for carrying out the treatment plans. (e) Criteria for release to less restrictive conditions and for discharge appear in the Hospital's new treatment plans; however, this section was not implemented in any of the records we saw. When criteria for attaining a given goal is specified and the patient progress is plotted against these criteria, you would have a measure of the patient's progress and thus the effectiveness

Senate Bill 377 adds the following stipulation regarding the review of each patient treatment plan: "The treatment plan shall be continuously reviewed by the professional person responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every ninety (90) days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by, a professional person other than the professional person responsible for supervising the implementation of the plan." Furthermore, it is the recommendation of the APA Committee on PSRO's that patients' records should be reviewed at the median length of stay for patients with similar diagnoses as locally determined and at intervals equal to half the median length of stay thereafter. Therefore at Warm Springs the first review should probably be at 90 days and every 45 days thereafter until discharged.

The Hospital should convene a Utilization Review Committee which should meet at least once a month. It is recommended that the URC utilize the services of the data processing system such that patients staying beyond a certain time, patients not recording progress, etc., would be flagged automatically. It is further recommended that until the Hospital passes accreditation by JCAH that an outside agency, such as the Mental Disabilities Board of Visitors, review the adequacy of patient care every 90 days.

At present, formal mechanisms for review are almost non-existent. We could see no record of periodic 90-day reviews of treatment plans including a mental examination. No formal guidelines (e.g., procedures manual) nor minutes were found for the operation of a Utilization Review Committee or a Medical Records Committee. Because of the understaffing of physicians, it is suggested that the Hospital superintendent formally designate other professionals as his representative to carry out some of these critical functions.

4. Progress notes by the nursing staff provided frequent and adequate descriptions of incidents and general behavior of each patient. However it was

often noted that changes in the patient status or treatment plans were not sufficiently justified. Assessment of progress was questionable in two cases and adequate in only one case. It is recommended that a simple rating scale be filled out every week for each patient or that his progress toward his goals (i.e., in terms of the criteria associated with each goal) be recorded weekly. It is also recommended that each professional and/or staff person who works with a patient record his progress weekly (e.g., his work supervisor, group therapy leader, etc.). In order to avoid excessive notes, it is suggested that notes reflect only changes in the patient's problems and needs or in his treatment plan (problem oriented progress notes).

5. Discharge Summary. Referral forms are now being filled out for all patients transferred to regional community mental health centers. However only three of eleven discharged patients reviewed had adequate discharge summaries including a final diagnosis. A written discharge plan describing the clinical course of hospitalization in terms of treatment plans, condition upon discharge, final diagnosis, and recommendations and arrangements for future treatment including medications should be part of the record, unless moving from Warn Springs back to a community mental health center could be considered a transfer from inpatient to outpatient service. Records of discharged patients should be completed within 15 days, including the signing of appropriate release forms.

At present the medical records would not pass either a typical PSRO review or the JCAH accreditation team. The records suffer primarily from a lack of administrative monitoring and backup. Clinicians are writing adequate summaries, but they need to justify what they do. Training of the entire professional staff in a single general approach to record keeping is greatly needed. This should be a continuous inservice training function. Many of the social work case reports go into great detail regarding the patient's past and present history, and in the same token some psychological testing reports

are unusually detailed. With the shortage of professional staff, it may be wiser to utilize these professionals more in direct patient care.

### C. Medications.

The clinical care of the seriously ill mental patient in a hospital should include a complete evaluation, an individualized treatment plan, progress notes, and after care planning. Psychotropic medications play a major role in the treatment of such patients. The skillful administration of these medications will be reflected in medical records which include the following: (a) a careful diagnosis of the clinical problems, (b) a clear statement of the rationale for each medication, (c) an evaluation of the response to treatment in the progress notes, and (d) a discharge summary which includes medication being given and projected future use.

In order to study the current patterns of administration of psychotropic medication at Warm Springs State Hospital, a population of 14 patients who had been hospitalized between the middle of 1975 and the present (April 7, 1976) were randomly selected and investigated in terms of the following parameters:

1. Diagnosis
2. Type of medication
3. Dosage
  - a. excessive
  - b. within normal standards
  - c. insufficient
4. Side Effects
  - a. present
  - b. absent
5. Management of Side Effects
  - a. nursing record of side effects and notification of MD
  - b. physician review (in progress notes)
  - c. physician orders appropriate action
6. Medication
  - a. correct class of medication for treatment of clinical problem
  - b. unnecessary
  - c. contra-indicated because of allergy, concurrent medical illness, etc.
7. Progress Notes About Response to Medication
8. Discharge Summary Specifying Dosage and Length of Use
9. Signatures
  - a. MD written order for medication



## Medications (continued)

b. Nurse's signature after medication is administered

### 10. Comments

Of the fourteen patients who were studied, twelve were placed on psychotropic medications. In reviewing the charts of these twelve patients, progress notes about medication were found to be absent in eight cases, inadequate in one case, and of questionable adequacy in one case. Only two charts had progress notes which clearly outlined the rationale for the use of specific medications, and response to treatment. In seven of these twelve cases, medications were prescribed which are generally not used for the treatment of the diagnoses listed for these patients. Although it is possible to infer that these medications might have been of some use in alleviating certain clinical problems of these patients, the physician did not write progress notes or treatment plans which specifically outline the problems for which the medications were given. (A summary of the diagnoses and medications given to these patients is included in Appendix D.) In one case there was a question of the appropriateness of the medication. The patient was an 83-year-old lady with mental confusion, an enlarged heart and emphysema. There was no notation on the chart of her blood pressure. She was given Thorazine which can lower blood pressure. This lady expired several days later, most probably from pre-existing medical diseases. Nonetheless, it is of crucial importance in elderly patients, who have compromised cardiopulmonary function, to monitor vital signs (BP, P) and level of consciousness at least every hour. There is no evidence that this was ordered by the physician.

Another area in which there was a major deficiency was the completion of discharge summaries. In eight of the ten patients discharged from the Hospital there were no discharge summaries. Since it has been documented and is common practice that maintenance medication on an outpatient basis is crucial in

preventing relapse, it is extremely important that a discharge summary include information about medication and dosage and be completed at or shortly after the time of discharge and sent to the appropriate outpatient clinic.

Side effects were noted in only one of the twelve patients and were communicated to a physician by the nursing staff. The physician took appropriate action. The dosage of medication was found to be appropriate for the severity of illness in ten of twelve cases. In one case, that of a patient with postpartum psychosis, the dosage of medication appeared to be inadequate. The patient was extremely psychotic and was intermittently placed in restraints and seclusion over a seven-day period. She was on a relatively small dose of medication which included Serenitil 50 mg. TID and Thorazine 75 mg. q 4 hr. PRN. The Thorazine was administered on only a few occasions. There was no progress note to indicate that the physician reviewed the status of the patient and her response to this pharmacological regimen. There was one case in which the dosage of medication may have been excessive. This has been outlined above in the case description of the 83-year-old woman given Thorazine.

#### Recommendation:

The major problem areas uncovered in this study of the administration of psychotropic medication are the the absence of a pharmacological treatment plan (or progress note) clearly outlining the specific clinical problems for which a medication is given, the absence of progress notes describing the response to this therapy, and the lack of discharge summaries. There were a number of cases in which the dosage and the use of specific drugs were questioned.

The first step in correcting these problems would be administrative guidelines directing that the medical staff include in the patient's chart pharmacologic treatment plans, progress notes outlining response to treatment and changes in medication, and discharge summaries completed at or shortly after release from hospital.



The second step would be to set up a Peer Evaluation and Utilization Review Committee at Warm Springs State Hospital. These committees could review patient records at regular intervals to monitor appropriateness and quality of Hospital treatment.

Thirdly, the medical records librarian should be responsible for reviewing records to see that all required elements (i.e., Discharge Summary) have been completed within a week after the patient is released.

Because of the serious deficiencies that exist at the present time at Warm Springs State Hospital, we would recommend that a Medical Audit Committee be set up which would be composed of professionals who are not affiliated with the Hospital. This impartial committee should conduct medical audit studies on a 90-day basis until some of the more serious problems at the Hospital are corrected.

### III. HUMANE PHYSICAL AND PSYCHOLOGICAL ENVIRONMENT

One of the main purposes of the new Montana State Law (Senate Bill No. 377), is to insure that each patient in a mental health facility receives care and treatment that is "skillfully and humanely administered with full respect for the person's dignity and personal integrity." When a patient's behavior is such that for his own safety or that of others he must be deprived of his liberty, any restrictive action that is taken must, by State and Federal Law, follow two basic steps: (1) patient must be provided the least restrictive alternative available, and (2) each patient must be provided due process of law. These policies are not only consistent with recent judicial decisions, but they are also consistent with the standards of psychiatric care required by the JCAH.

It is our impression that these basic guidelines for patients' rights were being compromised in the following areas: (1) in the Forensic Unit, (2) in the overuse of restraints and seclusion and, (3) in the restrictions to a patient's privacy and personal possessions.

#### A. The Forensic Unit.

The Forensic Unit at Warm Springs is not designed as a hospital unit, but as a maximum security prison with steel bars, electronic surveillance and a lack of privacy. Such a unit is often found in Correctional Facilities to handle convicted criminals who are "acting out," homicidal and suicidal or in psychiatric hospitals where the criminally insane are housed.

Most newly admitted patients sent to Warm Springs State Hospital on court commitment go through this Unit. Many of these patients have only minor offenses and were sent to Warm Springs because they were acting "odd." Many are not hardened criminals with homicidal, suicidal or aggressive tendencies. The Unit may be appropriate for the hard-to-handle, aggressive prisoner who is sent to Warm Springs for evaluation and for transfers from the State Prison. However, we question the psychological affect on a new admission to the State Hospital system who, because he is a court commitment, or because he was transferred from jail, is admitted to the Forensic Unit.

The staff on the Forensic Unit was kind and concerned; however the bleak prison atmosphere is not conducive to psychiatric rehabilitation. This is especially true for psychiatric, non-criminal patients. Patients who are management problems on other hospital wards should not be automatically sent to the Forensic Unit if other alternatives are available. The law specifically states that restrictive methods can not be used for punishment (e.g., Wyatt v. Stickney). It is our opinion that many psychiatric patients who are management problems can be treated more effectively on closed wards with medication, more intensive one-to-one staffing or by restraints and seclusions. There are a small number of psychiatric patients who may need to be confined to such a Unit for certain periods of time because they are either suicidal or homicidal or cannot be managed in any other way. Transfer to the Forensic Unit should be the last resort rather than an easy solution to an immediate problem.

Most outside review teams will respond to the stark, non-psychiatric nature of this Unit. Therefore, it is recommended that the civil rights of patients be communicated to each patient and visibly hung on the wall of each cell. The medical records should document that alternative methods have been tried without success and that the patient was given due process. It is also suggested that the patient know why he is in the Unit and for how long. Extensive periods of confinement for evaluation should be avoided. One patient in the Unit was in the process of evaluation for 90 days. We question the provision in the six-year-plan for Warm Springs State Hospital to enlarge the size of the Forensic Unit. In a state the size of Montana, the present Unit should seldom be filled.

#### B. Use of Restraints and Seclusion.

We found the use of restraints and seclusion to be more than usual. In part this excessive use appears to result from the routine order on charts, and even in treatment plans, that these techniques be used routinely as the treatment of choice for agitation. Outside reviewers might well question this assumption in the light of current practices in some Veterans Administration Hospitals which do not use restraints at all and seclusion rooms only in place of the Forensic Unit. The more preferred methods of handling agitated patients include medication and intensive one-to-one staffing.

Since patients have a right to the least restrictive care and the avoidance of cruel and unusual punishment, a hospital-wide policy for the use of restraints and seclusion should be formulated. Such a policy should appear in the Unit's procedure manual and adhere to the policy of Montana Law (Senate Bill #377, 38-1320). Not only is a written order of a professional person required for such action, but the order should explain the rationale for such action and other less restrictive alternatives explored and rejected in writing. We suggest the following standards for the use of restraints and/or seclusion: (1) a professional person must examine the patient and then justify the necessity for such action

by a written order. (2) written orders should be for no more than 24 hours. "PRN" orders are inappropriate. (3) a staff member must monitor the patient's physical and psychiatric condition at least every hour. (4) restraints and seclusion should be ordered only if: (a) pharmacological treatment and one-to-one staffing has failed to bring the problem under control, (b) the patient is physically aggressive to staff or other patients, (c) the patient exhibits excessive motor and/or verbal activity, or (d) the patient is dangerous to himself (self-destructive or suicidal). (5) patients in restraints and seclusion should be monitored at least every hour and, if medications are used concurrently, monitored every 15 minutes until the medications stabilize. (6) the written order, and each time the patient is monitored should be charted (recorded) similar to the charting and monitoring of a new medication.

#### C. Patient Rights and Privacy.

Privacy is a subjective concept. Our impression was, however, that individual privacy, dignity and self-determination could be enhanced in some areas by more patient responsibilities and more open wards. Compared to comparable size institutions, Warm Springs State Hospital seemed to have more closed wards. If this state of affairs is necessary, the reasons should be justified in the procedural manuals of the units concerned.

In the few units (closed wards) that we visited, patients' toilet articles (e.g., tooth brushes) were kept in the nursing station. In general there seems to be a tendency not to expect much responsibility from many patients. If this be the case, the level of responsibility or lack of responsibility should be noted as a problem, and one short-term goal should be its remediation. If post-hospital community existence becomes a major goal for most patients, then some of the policies reflecting an expectation of irresponsibility would tend to make it more difficult to adjust to post-hospital existence.



#### IV STAFFING PATTERNS

Many of the problems we have found and the questions we have asked are in part a result of an inadequate medical staffing pattern. The following is a comparison of the staffing pattern at Warm Springs State Hospital and the minimal standards set by the Wyatt-Stickney Court (based on a patient population of 700).

<u>Classification</u>	<u>Warm Springs State Hospital</u>	<u>Minimal Standards</u>
Psychiatrists	3 } 7	8 1/2 } 19
M.D.	4 }	11 }
R.N.	49	33 1/2
LPN	81	17
Aides	?	313 1/2
Psychologist (Ph.D.)	2 }	3 }
" (M.A.)	2 }	3 }
" (B.S.)	5 }	5 1/2 }
MSW and M.A.	5 } 12	5 1/2 } 19
Social Worker (A.B.)	7 }	14 }
Rehabilitation Counselor	0	3

Only three psychiatrists, two psychologists and three MSW's would qualify as a "Qualified Mental Health Professional" as defined by the Wyatt-Stickney Court. The minimal number of "Qualified Mental Health Professionals" for 700 patients would be 8 1/2 psychiatrists, three psychologists and 5 1/2 MSW's or 17 as compared to eight so qualified for Warm Springs State Hospital. An RN with a graduate degree in psychiatric nursing and two years of supervised clinical experience would also be considered a Qualified Mental Health Professional. From our data, we could not compute the number of "qualified" nurses. However, it is clear that the nursing service at Warm Springs State Hospital is adequately staffed.

Due to the shortage of psychiatrists and M.D.'s, non-medical duties such as ward and unit administration, psychotherapy, non-physical evaluations and the responsibility of patient's programs, care and records might better be delegated to qualified professional persons. The ultimate responsibility for patient care rests with M.D.'s; however, their role might better be one of supervision and consultation rather than direct care except in circumstances requiring medical attention.

## V ADMINISTRATIVE AND SUPPORT ACTIVITIES

Although we did not spend much time assessing administrative plans and procedures, some glaring omissions were seen. As mentioned earlier no utilization review or medical records committees were designated. Additional committees which might be established are a human rights committee, general administrative committee and a general clinical committee. Procedure manuals should be developed for key services such as Nursing, Medical Records, Forensic Service and Pharmaceutical Services. Nursing service was well organized and had an updated procedure manual on each ward.

The assignment of a trained hospital administrator to that position should improve the administrative functioning and provide more support to the clinical services. Accreditation is now more likely to occur as more efficient management practices develop.

## VI GENERAL IMPRESSIONS

There seemed to be some patients who did not belong at Warm Springs State Hospital. For example, many patients, if not all, could be evaluated closer to home at the local Community Mental Health Center. Those patients whose primary diagnosis is Mental Retardation and those under 18 years of age might better be placed at Boulder or some other facility where treatment and schooling could go hand in hand. On March 25, 1976, 101 patients were classified as Mental Retardates. Billings, Bozeman or Missoula might be a better location for a Children's Program. Closer ties could be developed with the Universities, and it would be easier to attract qualified professionals especially M.D.'s. Nevertheless, we were impressed with the quality of the psychiatric aides at Warm Springs State Hospital. They seem to be more capable than attendants in similar institutions. Professionals requiring a bit more "intellectual" stimulation for themselves and their families would be more readily attracted to a College or University community than to Warm Springs. In order to attract M.D.'s and Ph.D.'s



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to Warm Springs, affiliation with the University of Washington and the State Universities of Montana would be helpful. With the requirements for continued education to maintain one's license, M.D.'s and Ph.D.'s will be looking for seminars and workshops to attend. Continued professional education should be considered in future budgeting. Thus, University of Washington faculty members and others could be brought in to give workshops in particular techniques and programs. The results should be an upgrading of treatment throughout the State.

Up to this point, our review of Warm Springs State Hospital for the Board of Visitors has focused on deficiencies that exist at the hospital and possible remedies. There are, however, indications that a considerable amount of progress has been made and that the outlook for the future is brighter.

Dramatic improvements in the quality of care delivered at Warm Springs State Hospital have occurred over the past year. Complete psychiatric examinations and detailed social and psychological assessments have begun to appear in the medical records. Individualized treatment plans are now being developed. A proposed agreement with the Department of Psychiatry at the University of Washington to have residents and professors rotate through Warm Springs should help to further improve the quality of care. The present affiliation of the nursing school at Bozeman with the Hospital has considerably enhanced the therapeutic effectiveness of the nursing service as has the LPN School. Increased liaison with the Departments of Clinical Psychology, Social Work, Rehabilitation and Activity Therapies at the State Universities could result in additional improvement at the Hospital.

There are, however, other factors which must be considered when thinking about the future of this hospital. The trend in modern psychiatric care is toward treatment of patients in their home community. This trend, of course, makes large institutions like Warm Springs State Hospital somewhat obsolete. In future planning we would recommend that the State of Montana direct its effort

towards the development of small inpatient psychiatric services in community hospitals which would be associated with existing community mental health centers and local rehabilitation centers focusing on work skills, social and community survival skills and residential programs. Patients from areas of the State that don't have such inpatient or rehabilitation units and those whose illness is especially severe and protracted could be referred to Warm Springs State Hospital for further care. Habilitation as well as rehabilitation units should be established for those patients who are not able to return to their community after several months of treatment. These non-hospital units might be set up both on and off the grounds of Warm Springs State Hospital and staffed by habilitation specialists. Psychiatrists, other physicians, psychologists, social workers and nurses could be called in as consultants when needed.

This plan coupled with the present policy of limiting hospitalization at Warm Springs State Hospital to only psychiatric patients would result in a reduction of the patient population to a more manageable number (i.e. about 200 patients). As a result of the higher staff-patient ratio more intensive and higher quality treatment could be delivered.

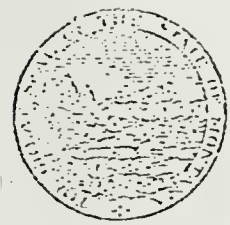
## APPENDIX A

### Sample Computerized Records

1. A sample outpatient service slip for management information, clinical research and billing
2. A sample admissions record including problem appraisal
3. The Multistate Information System. One example of the numerous data processing systems readily available for psychiatric patients

APPENDIX 4-F

NOTIFICATION LETTER TO WSSH FROM BOARD OF VISITORS



STATE OF MONTANA  
Office of the Governor  
Mental Disabilities Board of Visitors  
Capitol Building - Helena, Montana 59601

Thomas L. Judge  
Governor

Room 221, Power Block  
Helena MT 59601  
May 3, 1976

Dr. Harry C. Xanthopoulos  
Superintendent  
Warm Springs State Hospital  
Warm Springs MT 59756

REF: 76H-057

Dear Dr. Xanthopoulos:

From April 6 through April 8, 1976, the Mental Disabilities Board of Visitors accompanied by Dr. Rochford and Dr. Atthowe of Rutgers Medical School made an inspection visit to Warm Springs State Hospital. The purpose of this visit was to carry out the duties and responsibilities given to the Board of Visitors by Title 38 of the Revised Codes of Montana, and in particular:

1. To assess medical records with specific reference to medication.
2. To assess medical and other records for evidence of compliance with statutory commitment procedures and treatment plans.
3. To evaluate record keeping systems in view of the requirements of Title 38 of the Revised Codes of Montana.
4. To investigate the care and treatment of randomly selected patients, as well as two patients in particular referred to the Board of Visitors.

As a result of this visitation, the Mental Disabilities Board of Visitors is herewith reporting. In accord with the law, the report is being forwarded to the Director of the Department of Institutions and the Honorable Judge Olson. Receipt of this report constitutes a request that noted exceptions and violations of law be corrected without delay. We request that you submit evidence of compliance or when appropriate, your projected timeline for compliance to the Board of Visitors within 14 days of receipt of this report.

Dr. Harry C. Xanthopoulos  
May 3, 1976  
Page 2

Enclosed with the report is a list of violations according to R.C.M. Title 38. This includes the section number violated, specific case numbers, and page references from the report. We suggest this appendix be used when reading the consultants' report and when complying with the noted exceptions therein set forth.

Sincerely,

Dr. J. Francis Rummel, Chairman  
Mental Disabilities Board of Visitors

JFR/mef

Enclosures:

Appendix: List of violations with reference to report, R.C.M. Section, and patient identification number (where appropriate or known).

Review of Warm Springs State Hospital for the State Board of Visitors/Consultants' Report.

cc Judge Boyd  
Dr. Bob Mattson





STATE OF MONTANA  
Office of the Governor  
Mental Disabilities Board of Visitors  
Capitol Building - Helena, Montana 59601

Thomas L. Judge  
Governor

Room 221, Power Block  
Helena, MT 59601  
May 3, 1976

Robert H. Mattson, Director  
Department of Institutions  
1539 Eleventh Avenue  
Helena, Montana 59601

Dear Mr. Mattson:

Attached is your copy of a letter and attachments  
mailed to Dr. Xanthopoulos, Superintendent of Warm Springs  
State Hospital, which lists certain violations of R.C.M.  
Title 38.

Sincerely,

Dr. J. Francis Rummel, Chairman  
Mental Disabilities Board of Visitors

JFR/maf

Enclosures



STATE OF MONTANA  
Office of the Governor  
Mental Disabilities Board of Visitors  
Capitol Building - Helena, Montana 59601

Thomas L. Judge  
Governor

Room 221, Power Block  
Helena, MT 59601  
May 27, 1976

Honorable Judge Boyd  
Deer Lodge County Court House  
Anaconda, Montana 59711

Dear Judge Boyd:

Attached is your copy of a letter and attachments  
mailed to Dr. Xanthopoulos, Superintendent of Warm  
Springs State Hospital, which lists certain violations  
of R.C.M. Title 38.

Sincerely,

Dr. J. Francis Rummel, Chairman  
Mental Disabilities Board of Visitors

JFR/maf

Enclosures

Appendix:

List of violations with reference to narrative report,  
R.C.M. Section, and patient identification  
number (where appropriate or known)

Page # of  
Consultants'  
Report.

Violation of Law

RCM Title 38

Section No.

Patient Number

2	Inadequate Medical Records	1328	
3	Patient Treatment Plan Record of Progress	1328(11)	
4	Missing Physical Exams (8 of 19)	1328(5)	
4	Improper Commitment Procedures	1305, 1306, 1309	
4	Missing Treatment Plans	1328(6), 1324(2)	
4	Incomplete Treatment Plans i.e. problems and needs (17 of 19)	1324(2) (a)	
5	Treatment Plan without timetable for goals (16 of 19)	1324(2) (c)	
5	Treatment plan not specific nor individualized	1324(2) (a)	
5	No staff responsibility designated (19 of 19)	1324(2) (e)	
5	Failure to release to less restric- tive when goal is met	1324(2) (f)	
6	Specific Aftercare Plan missing (12 of 19)	1324(3)	
7	Failure to record and review patient plans	1324(5)	
7	Failure to examine patient every 90 days by other professional	1324(5)	
8	Inadequate or Missing Discharge Sum- mary and Final Diagnosis	1326	

Page # of  
Consultants'  
Report

Violation of Law

RCM Title 38  
Section No.

Patient Number

10	Medications: notes on use missing (8 of 14)	1319, 1328(9)	
10	Failure to note physician ordering medication; death	1328(9), 1319	
11	No justification for medication as part of Plan	1328(9), 1319	
12	Over restraint/due process/forensic unit	1306(5), 1317, 1304	
13	Forensic Unit	1306(5), 1317	
17	Utilization Review	1324(5)	

Room 221, Power Block  
Helena, MT 59501  
May 12, 1976

Dr. Xanthopoulos, Superintendent  
Warm Springs State Hospital  
Warm Springs, MT 59756

ATTENTION: Mr. Richard Moore, Administrator

Dear Dr. Xanthopoulos:

It has been brought to our attention that the Appendix, "List of Violations With Reference to Report, R.C.M. Section, and Patient Identification," was missing from the official report received by you. You will find the Appendix enclosed with this letter which also serves as notice that the two week period for compliance will begin with receipt of the Appendix herein contained.

I apologize for the delay and inconvenience.

Sincerely,

Ms. Jan Hall, Recording Secretary  
Mental Disabilities Board of Visitors

Enc: Appendix: List of Violations With Reference to Report, R.C.M. Section, and Patient Identification

jh

APPENDIX 4-G

WSSH RESPONSE TO BOARD OF VISITORS NOTIFICATION



# Warm Springs State Hospital

ADDRESS CORRESPONDENCE TO  
WARM SPRINGS STATE HOSPITAL

WARM SPRINGS, MONTANA 59756

WHEN WRITING  
PLEASE GIVE NAME OF PATIENT

VISITING HOURS  
9-11 A.M. 1-4 P.M. DAILY

C. Anthopoulos, M.D.  
Superintendent

June 1, 1976

Dr. J. Francis Rummel  
Chairman  
Mental Disabilities Board of Visitors  
Room 221, Power Block  
Capitol Building  
Helena, Montana 59601

Re: 76H-057 - Warm Springs State Hospital

Dear Dr. Rummel:

This letter is in response to your correspondence of May 3rd regarding the consultant's report on the visit to Warm Springs State Hospital.

We were pleased that the consultants recognized the substantial improvements in the quality of care, documentation and delivery of services to the patients. The report did highlight a number of deficiencies which must be immediately corrected. There was basic agreement among the staff with respect to the report. Responsibility and accountability are important functions for appropriate performance.

The addition of two record room administrators on June 1 and 14th respectively, will allow us to improve the documentation and followup which is necessary to assure quality of care. There will be a reorganization within the next two months which is based upon program accountability and management by objectives. A new treatment plan with appropriate progress notes has been implemented during the current month.

Warm Springs State Hospital has to be oriented along community lines, with the focus of attention as a base hospital for the seriously mentally ill. Education of allied health professionals is an important role in our facility. The affiliation with the University of Washington Medical School for the rotation of three residents in psychiatry is an important step forward towards enhancing the quality of care. Our major short term objective is to seek full accreditation by the Joint Commission on Accreditation of Hospitals (Psychiatric).

There were some comments noted in the consultant's report which need to be clarified. The Utilization Committee has functioned in an appropriate manner since January of 1976 but was held in abeyance at the time the licenses were not in effect. Subsequently we have received appropriate licenses by the Department of Health retroactive to February. There were also comments relating to the detailed reports by the psychologists. It is their professional opinion that detailed reporting of dynamics is most helpful and even necessary, prior to engaging the patient in meaningful psychotherapy. At the same time, psychological evaluations for all patients are not appropriate or necessary.

Dr, J. Francis Rummel

Page Two

June 1, 1976

The attached information reflects our time line for compliance and pertinent comments per your request. If you have any questions, please do not hesitate in contacting Mr. Moore or myself at (406)693-2221, Extension 2350 or Extension 2320.

Yours very truly,

*Harry C. Xanthopoulos, M.D.*

Harry C. Xanthopoulos, M.D.  
Superintendent

*Richard T. Moore*

Richard T. Moore  
Hospital Administrator

RTM/alm

Attachment

cc: T. Boland  
Judge Boyd  
B. Mattson  
L. Carlson

WARM SPRINGS STATE HOSPITAL

Board of Visitor's

DEFICIENCY	COMMENTS	TIME LINE
# Inadequate Medical Records	Two Record Room Administrators have been hired and will be responsible for supervision and insuring appropriate documentation in the medical records department.  6/1/76 Doris Brander Dept Head (R.R.A. eligible)  6/14/76 Kathleen Froemming Record Room Administrator R.R.A. Licensed).	7/1/76
# Patient Treatment plan/progress notes	New Treatment Plans and Progress notes are in use in all regions - (see attached). A written policy on treatment plans and staff progress notes is also enclosed. Our procedures will be as follows:	7/10/76
a) Physical Exam	1) Individual Treatment plans on the carex file which is modified according to the individual patient's situation, will be specific and individualized.	
b) incomplete		
c) without time tables for goals	2) Progress will be evaluated frequently at team meetings with the patient in attendance. (at least weekly).	
d) not specific nor individualized	3) Physical examinations including urinalysis and CBC are required at time of admission and as needed during their stay.	
e) no stated responsibility designated	4) Nursing care plans will be incorporated into the individualized treatment plan.	
f) Release to less restrictive situations when goal is met.	5) Goals with time tables will have to be subject to change depending upon an individual patient's progress.	
g) aftercare plan	6) There will be designated staff responsibility. We will engage a ward staff in more active participation with designated patients (Daily monitoring) in reference to specifics of treatment plan.	
h) record and review patient plan on a regular basis	7) We anticipate no problem in releasing patient's to a less restrictive situation when a treatment goal is met. Staff should be alerted to progress which progressively allows for more freedom, stimulations and self development. Insofar as patients are capable of being responsible for themselves, we must provide them with the possibility for that responsibility.	

## DEFICIENCY

## COMMENTS

## TIME LINE

Patient  
Treatment  
plan/progress  
notes  
Continued.

8) Treatment plans and the medical chart will reflect release plans and aftercare plans. It is necessary to find a placement which is appropriate to his particular situation and will provide aftercare considered necessary for his continued well being.

7/10/76

9) Arrangements have been made for reviewing and recording patient plans within specified time limits and rotation of professionals for review. A professional person will review and evaluate a patient's progress in reference to plan specifications and as a consultant for plan modifications as specified within the law.

# Inadequate  
Discharge  
Summary

We will receive all discharge summaries with final diagnosis to be prepared within fifteen (15) days after discharge. Rationals for discharge and aftercare plan including medical treatments, current medications will be incorporated.

7/1/76

# Medications  
a) notes on  
use missing  
  
b) Justification  
for Medication  
as part of plan  
  
c) one case where  
the physicians  
name was not  
mentioned in  
the ordering  
of medication.

Although the ordering of medication is the responsibility of attending physicians, it is the responsibility of other knowledgeable professionals to bring to the attention of the attending physicians pertinent observations. There will be discussion at the quarterly medical staff meeting concerning the feasibility of clinical pharmacists prescribing and monitoring psychotropic drug therapy, conducting patient interviews and adjusting medication according to patient response. The pharmacist is responsible for maintaining a drug history on each patient (Drug Profile)

8/1/76

# Over restraint/  
Due process

See attached policy on restraint, mechanical and seclusion. It is not the policy to use restraints and seclusion as a punitive measure. At times restraint or seclusion is necessary for the patient's own protection, for that of other patients and ward personnel.

in effect

# Forensic Unit

See attached addendum.  
We have proposed to the department of Institutions a capital construction program of facilities for patient's which meets the standards outlines in S.B. 377.

Building  
Program

HOSPITAL OPERATING POLICY AND PROCEDURE

WARM SPRINGS STATE HOSPITAL  
Warm Springs, Montana

H.O.P.P.#

SUBJECT: Treatment Plan

DEPARTMENTS AFFECTED: Nursing Service  
Region Treatment Teams  
All Clinical Departments

PURPOSE: To provide a current, on-going, individualized plan of care and treatment for each patient.

GOALS: To evaluate and document the specific problems and needs of each patient.

To determine the least restrictive conditions necessary in achieving care and treatment.

To formulate treatment goals, with a projected timetable for their attainment.

To specify staff responsibility in implementing approaches which meet treatment goals.

To plan and note therapeutic tasks performed by the patient.

To establish criteria for release to a less restrictive environment, including an after care plan.

To facilitate continuity of care and treatment during hospitalization and following discharge.

PROCEDURE: A. General Information

1. Each patient admitted for a period of more than seventy-two (72) hours shall have an individualized plan of treatment established. This plan shall be developed by the Region Treatment Team, no later than five (5) days following admission.
2. In the interests of continuity of care, one professional person and/or case coordinator shall be responsible for approving and supervising the implementation of the treatment plan and integrating the various aspects of the treatment program.



3. The treatment plan shall be continuously reviewed and modified when necessary, which will be indicated by the date preceding each entry.
4. Examination and evaluation reviews will be carried out by date due and indicated on the plan.
5. The patient should be involved in the formulation of his treatment plan.

B. Rules to Observe

1. THE ONLY PERSON ALLOWED TO MAKE ENTRIES ON THE TREATMENT PLAN IS THAT INDIVIDUAL ASSIGNED BY THE PROFESSIONAL PERSON.
2. The treatment plan is a permanent record; therefore, all notations must be type written or neatly printed in black ink. Erasures are not allowed.
3. New problems and/or approaches must be brought to the attention of the Treatment Team, who will then decide whether the problem is significant enough to be entered on the Treatment Plan, or whether the recommended approach should be followed. If approved, the assigned person will appropriately record.

In implementing the above procedure, all nursing staff members will:

- a. Report any observation which might indicate a new problem and/or approach.
  - b. Record such information on the Staff Progress Notes, on Nurses Notes when applicable. In order to ensure immediate communication to the Region Nurse, notations should also be made on the Supervisor's Report.
  - c. Make requests to carry out Special Projects or Nursing Treatment Modalities (i.e. Remotivation, Nurse-Patient Relationship) to the Region Nurse for approval by the Treatment Team.
4. Discontinued medications or treatments will not be erased. Draw a single, red horizontal line through the entry. Record, in red, the discontinued date.
  5. Specific instructions in recording on the Problem-Approach section are:
    - a. One line should separate each problem and approach.



- b. The name of the person responsible for implementing the approach is recorded in the "By" column.
- c. The time of day and days of the week when session is held will be recorded in the "Time" column.
- d. If an approach is not specific in relation to time, or is to be met by many individuals, no entry is made in these two areas.
- e. Should a problem or approach require modification, or no longer be necessary, a notation should be made on the blank line in appropriate column, in red, as indicated:  
Modified, Date  
Not, Date

### EXAMPLE

DATE	PROBLEM	APPROACH	TIME	BY
3/16/75	UNABLE TO SOCIALIZE WITH GROUP; WITH- DRAWS FROM GROUP ACTIVITIES.	REINTEGRATION GROUP	1:00 PM.	J. Smith, P.T.
	MET - 6/18/75 (RED INK)		WED	
4/1/75	LOSS OF APPETITE	SIT WITH DURING MEALS AND ENCOURAGE; NOTE INTAKE; WEIGH WEEKLY.	NURSING RM.	
4/5/75	FEELINGS OF REJECTION	ALLOW HER TO VENTILIZE FEELINGS SHOW ACCEPTANCE		

Date of Origin	Effective Date	Date of Revision	Hospital Superintendent
April, 1976	May, 1976		H. C. Koutianos, M.D.
			Department Head
			<i>[Signature]</i>

MEMORANDUM

May 10, 1976

To: Registered Nurses  
Licensed Practical Nurses

From: Beverly Murray, R.N.  
Program Coordinator

Re: Treatment Plan and Staff Progress Notes, Policy and Procedure

Mandatory classes explaining the use of the treatment plan and staff progress notes will be held according to the following schedule on Infirmary 18:

May 13, 1976—11:00am—3:30pm

May 14, 1976—11:00am—3:30pm

May 18, 1976—9:00am

May 20, 1976—7:00pm

May 21, 1976—11:00am—3:30pm

Members of the treatment team are welcome to attend.

MEMORANDUM

May 7, 1976

TO: Region Treatment Teams

FROM: Harry C. Xanthopoulos, M.D. *HX*  
Superintendent

RE: Treatment Plan  
Staff Progress Notes

The newly adopted TREATMENT PLANS and STAFF PROGRESS NOTES are to be implemented for all patients on all regions beginning May 24, 1976 for a six months' trial. Following this period, recommended revisions will be considered.

The Nursing Service Department will be conducting classes regarding the correct procedure to be followed in completing these forms. Your attendance will be appreciated.

HX/sr

# HOSPITAL OPERATING POLICY AND PROCEDURE

WARM SPRINGS STATE HOSPITAL  
Warm Springs, Montana

H.O.P.P. #

SUBJECT: Restraint, Mechanical and Seclusion

DEPARTMENT AFFECTED: Nursing Service

PURPOSE: To insure a safe and therapeutic environment for all patients and employees.

POLICY: To provide that in emergency situations, in which it is likely, that patients would harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation.

PROCEDURE:

1. Restraint shall be for no more than one hour, by which time a professional person shall have been consulted and shall have entered an appropriate order in writing.
2. Such written order shall be affective for no more than twenty-four hours and must be renewed if restraint or isolation are to be continued.
3. Whenever a patient is subject to restraint or isolation, adequate care shall be taken to monitor his physical and psychiatric condition and to provide for his physical needs and comfort.

Date of Origin

Effective Date

Date of Revision

Hospital Superintendent

July, 1973

August, 1973

August, 1975

*Harry C. Xanthopoulos, M.D.*

Department Head

*Gene Edwards, R.N., J.D.*

HOSPITAL OPERATING POLICY AND PROCEDURE

WARM SPRINGS STATE HOSPITAL  
Warm Springs, Montana

H.O.P.P.#

SUBJECT: Charting - Staff Progress Notes

DEPARTMENTS AFFECTED: Nursing Service  
All Clinical Departments

PURPOSE: To provide documentation which reflects the changing status of the patient, the results of therapeutic approaches, and the outlining or suggestions of additional or changing needs and approaches.

POLICY: A progress note should be made whenever there is a change in the patient's behavior or his treatment, whenever there is a need to indicate response (or lack of) to a specific approach or treatment, or when a specific problem or incident has resulted in change of patient status.

PROCEDURE:

1. All staff members will record progress notes on the "Staff Progress Notes" form in the patient's chart.
2. "Rules to Observe In Charting" must be followed when making entries.
3. Progress Notes must be dated and signed by the person who made the notation.
4. The Region Treatment Team will be responsible for determining the minimum criterion for the frequency with which progress notes will be made.
5. Unless specifically indicated, it will no longer be necessary to make daily routine entries on the "Nurses Notes."
6. If "Nurses Notes" are indicated (see "Charting-Nurses Notes"), a summary of those notes will be incorporated into the progress notes.
7. Whenever it is necessary to begin or discontinue "Nurses Notes," a statement indicating reason and date must be entered on the progress note.

8. The Nursing Audit Committee will meet regularly and will have responsibility to:
- a. Review progress notes and determine adequacy.
  - b. Notify nursing staff member if correct procedure is not being followed.
  - c. Submit periodic report to Director of Nursing

Date of Origin	Effective Date	Date of Revision	Hospital Superintendent
April, 1976	May, 1976		<i>H. C. Xantopoulos, M.D.</i>
			Department Head
			<i>James Edwards, R.N.</i>



# UTILIZATION REVIEW PLAN

## WARM SPRINGS STATE HOSPITAL

### AUTHORITY:

The Utilization Review Committee is established as a standing committee by the Medical Staff of Warm Springs State Hospital, and in accordance with the Medical Staff's bylaws. The Superintendent is the Chairman of the Medical Staff, and the following plan is approved by him and the Medical Staff.

### PURPOSE:

The purpose of the Utilization Review Committee is:

1. To assure the highest possible degree of medical care for all patients, particularly those requiring skilled nursing services.
2. To increase effective utilization of available facilities for extended care, safety, and comfort of our patients.
3. Review and evaluation of clinical practices within our facility.
4. Taking an educational approach involving studies and evaluations.
5. To inform staff of Federal and State criteria and recommend changes, as indicated.

### ORGANIZATION:

The Utilization Review Committee is composed of two physicians appointed by the Chairman, one Social Worker appointed by the Director of Social Services, a Registered Nurse, a representative of the Medical Records Department, and a Recording Secretary. Other professional and/or non-professional personnel may be appointed or requested to attend as deemed necessary.

Physicians will be contracted with or appointed by the Superintendent or his designated representative. The Medical Records Librarian will attend, or designate a representative in his/her absence. The R.N. who is Coordinator for Medicare and Medicaid or an appointee from the Director of Nursing will attend. A recording secretary will be appointed by the R.N. Coordinator.

Inasmuch as there may be a change in the names of the staff or members participating in the Utilization Review, in order to allow for turnover, vacations, illness, etc. please see listing attached.

### MEETINGS:

Meetings of the entire Committee will be held every fourteen days. The Chairman may call a special meeting at any time, giving three days notice if possible to the other members. Physician members may make a timely, preliminary, individual evaluation of extended duration cases that may come up between meetings, and take appropriate action subject to approval at the next regularly scheduled meeting. If the action results in a conclusion that further in-patient psychiatric or medical-surgical care is not medically necessary on an active treatment basis the reviewing physician shall promptly discuss the proposed action with the Clinical Director and other members of the Committee and if necessary have a special meeting called by the Chairman to consider the decision. Notices of the meetings will be sent in writing to those involved at least two days before the scheduled meeting. Dates may be subject to change.

### RECORDS:

Minutes of the Utilization Review Committee meetings will be kept by the recording secretary. These minutes will be approved and signed by the Chairman, and copies kept on file by the recording secretary, the Coordinator, and the Division of Social Rehabilitation Services. Any data compiled specifically for the meetings will also be kept and filed. Any action taken on an extended care case by the Committee will be identified only

#### METHODS OF REVIEW:

- I. The Utilization Review Committee will review all Medicaid and Medicare admissions at the first meeting following admission. That this meeting, determination as to need of re-certification will be made by the Committee, and level of care decided by the Committee. Medical Records will furnish the Coordinator with admission information regarding Medicare and Medicaid patients.
- II. Patients receiving extended care, who, are in the opinion of the Committee receiving skilled level of care will have their cases reviewed every thirty days. Skilled level of care will be decided using criteria attached, as suggested by Montana State Welfare Department.  
  
Intermediate A will be reviewed every sixty days, and Intermediate B every ninety days.
- III. The Committee may review some cases discharged to other facilities. This review shall include medical necessity and services involved.
- IV. Charts on all deaths will be reviewed at the meeting immediately following date of death.
- V. The Utilization Review Committee will use the following resources as necessary in performing their function.
  1. Complete Medical Records (ward copy and main file)
  2. Face sheet of Medical Record
  3. Check list prepared by Coordinator
  4. Interview with the attending physician and/or interview or observation of the patient if considered necessary.
  5. Any input requested by the Committee from any ancillary department of the Hospital.
- VI. Whenever the Utilization Review Committee deems it necessary, they will subject cases to in-depth peer review in order to correct deficiencies and assure high quality care.
- VII. All actions taken by the Committee will be documented and notification given to the physician or discipline involved by the recording secretary no later than one day following meeting, a copy being retained in the secretary's files.

#### CONTINUED STAY REVIEW:

Patients considered by the Committee to require skilled level of care, and to be reviewed at least every thirty days, will have a file kept by the Coordinator and she will schedule the charts to be reviewed. Data on these patients will be condensed on a review sheet for the convenience and expedience of the Committee, and recommendations may be included.

If the Committee considers a change of the level of care is indicated, the Coordinator will fill in the appropriate information on the General 65 form and copies will be routed to the appropriate recipients.

#### MEDICAL CARE EVALUATION STUDIES:

The Utilization Review Committee will coordinate medical care evaluation studies, making certain at least one study is in progress at all times. The secretary will maintain copies of all study results as well as all the minutes of the meetings of the Committee. Any actions taken on the basis of Medical Care Evaluation Studies will be documented and copies made available to the Medical Staff and Administration. Each individual evaluation Study will last no longer than one year for the purposes of the

RELATIONSHIPS TO THIRD PARTY PAYORS:

Procedures and minutes of the Utilization Review Committee will be open to review by State Agencies, Department of Health, Education and Welfare, Division of Social Rehabilitation Services, with required data and information available and every precaution to insure confidentiality of information will be maintained.

The Coordinator will provide level of care information to the Reimbursement Division, the Eligibility Technician, and Medical Records. Every effort will be made to cooperate with those agencies involved with pre-payment plans.

RESPONSIBILITIES OF ADMINISTRATION:

Hospital Administration will provide assistance and cooperation with the Utilization Review Committee by participating in the review processes, furnishing adequate meeting facilities, providing needed information, forms, supplies, and taking required action to facilitate recommended changes and expressed needs. Administration will also see that required medical and nursing information is readily available when requested, and that a free flow of communication is encouraged.

APPROVAL Harry C. Xanthopoulos, M.D. DATE 12-17-75  
Superintendent

APPROVAL William N. Alexander, M.D. DATE 12-17-75  
Clinical Director

## ADDENDUM TO UTILIZATION REVIEW PLAN

The members of the committee of the utilization review plan will be:

1. Chairman, Dr. Harry C. Xanthopoulos, Superintendent; and Dr. William Alexander, Clinical Director, with alternates either Dr. Lars Slette or Dr. Floyd Stancliffe.
2. Representatives from Social Service would be Gregory Jacobs, Director of Social Service, with alternate Dick Rosenleaf, Assistant Director of Social Service.
3. Representative from Medical Records would be George Maxwell, (tentative), with alternate Paulette Lorello.
4. Medicare-Medicaid Coordinator would be Kay Ozanich, R.N., with alternate Doris Flink, R.N., Assistant Director of Nursing.
5. Recording secretary would be Janice Isaacson with alternate Joan Delaney.

APPENDIX 4-H

BOARD OF VISITORS SECOND REQUEST TO WSSH





STATE OF MONTANA  
Office of the Governor  
Mental Disabilities Board of Visitors  
Capitol Building - Helena, Montana 59601

Thomas L. Judge  
Governor

Room 221, Power Block  
Helena, Montana 59601

June 30, 1976

Dr. Harry Xanthopoulos  
Superintendent  
Warm Springs State Hospital  
Warm Springs, Montana 59756

Dear Dr. Xanthopoulos:

On June 1, 1976 you replied to the Board of Visitors' request for compliance with Montana law. Your response was read and discussed at a Board of Visitors' meeting held in Great Falls on June 25, 1976. Your response was found to be vague as it applied to specific patients under your care at Warm Springs State Hospital and as it applied to the Forensic Unit.

The Board of Visitors, to fulfill its obligations under Montana law, must have more information regarding the specific cases cited in its report on Warm Springs and therefore writes to inform you that a hearing will be held in the near future in the Governor's chambers. The purpose of the hearing will be to acquire a more definitive response from you and your staff regarding the cases and issues raised in the Board's letter to you dated May 3, 1976.

Please be assured that you will be given ample notice of the date and time of this hearing.

Very truly yours,

A handwritten signature in cursive script, reading "Thomas Boland", is written over the typed name.

Thomas Boland, Attorney  
Executive Director

jh

cc: Board of Visitors



APPENDIX 5-A

BOARD OF VISITORS VISIT SCHEDULE

11/5/75 to 6/30/76

# VISIT SCHEDULE OF THE BOARD OF VISITORS

11/5/75 to 6/30/76

DATE	LOCATION	BOARD MEMBERS PRESENT	CONSULTANTS	PURPOSE
12/4/75	Billings	Rummel, Hamerlynck, Ashton, Hansen, Harr	None	1st meeting and visit to Region III Mental Health Center
1/14-15/76	Warm Springs	Rummel, Hamerlynck, Ashton, Hansen	Dr. Harr	1st visit to WSSH
1/16/76	Boulder	Rummel, Hamerlynck, Ashton, Hansen	Dr. Harr	1st visit to BRS&H
2/6/76	Glendive	Hansen	None	Site visit to Eastmont Training Center
2/18/76	Helena	Rummel, Hamerlynck, Ashton, Hansen	Naomi Kennedy	Board meeting and visit with NIMH to Region IV Mental Health Center
3/12/76	Missoula	Rummel, Hamerlynck, Ashton, Hansen	None	Board meeting and visit to Region V Mental Health Center
4/6-7-8/76	Warm Springs	Hamerlynck	Dr. Atthowe, Dr. Rochford	WSSH site visit
4/6/76	Miles City	Ashton, Hansen	None	Visit to Region I Mental Health Center
4/7/76	Lewistown	Ashton, Hansen	None	Visit to Home for the Aged
4/7/76	Great Falls	Ashton, Hansen	None	Visit to Region II Mental Health Center
4/8/76	Helena	Hamerlynck, Ashton, Hansen	Dr. Atthowe, Dr. Rochford, Ms. Zion, Ms. Uda	Board meeting and discussion of visits and Handbooks

# VISIT SCHEDULE OF THE BOARD OF VISITORS (cont.)

11/5/75 to 6/30/76

DATE	LOCATION	BOARD MEMBERS PRESENT	CONSULTANTS	PURPOSE
4/12/76	Helena	Hamerlynck, Hansen, Ashton	Ms. Zion, Attorney	Meeting regarding handbooks
4/19, 16/76	Helena	Rummel, Hamerlynck, Ashton, Hansen, Stimpfling	None	Board meeting
5/26-27/76	Helena	Rummel, Hamerlynck, Ashton, Hansen, Stimpfling, Boland (Ex. Dir.)	None	Board meeting and drafting of annual report to the Governor
6/14/76	Galen	Stimpfling, Ashton	None	1st visit to Galen
6/25/76	Great Falls	Rummel, Hamerlynck, Ashton, Hansen, Stimpfling, Boland (Ex. Dir.)	None	Board meeting and final draft of annual report to the Governor

APPENDIX 5-B

TABLE OF VISIT FINDINGS

TABLE OF VISIT FINDINGS  
11/5/75 to 6/30/76

The table below lists the facilities under the jurisdiction of the Board of Visitors in the column to the left and the subsections of R.C.M. 38-1330, which will be subjects of investigation, follow to the right. This table will facilitate the review procedures of the Board of Visitors in the months and years ahead.

SITE	R.C.M. 38-1330 SUBSECTIONS					INVESTIGATION
	Experimental Research (3)	Physical Plant (4)	Treatment Plans (5)	Patient Grievances (8)	Compliance Failure (7)	
WSSH		Appendix 4-E	Appendix 4-E		Appendix 4-G	
DRSSH		Ann. Rep. p.7				
		Appendix 3-A				
Eastmont		Ann. Rep. p.6				
		Annual Report to the Gov., p.5				
Home for the Aged		Annual Report to the Gov., p.4				
Galen		Annual Report to the Gov., p.10				
Mental Health Centers						
Region I		Annual Report to the Gov., p.2				
Region II		Annual Report to the Gov., p.2				
Region III		Annual Report to the Gov., p.3				
Region IV		Annual Report to the Gov., p.3				
Region V		Annual Report to the Gov., p.4				

APPENDIX 6-A

BRS&H HUMAN RIGHTS COMMITTEE



# Boulder River School & Hospital

BOULDER, MONTANA 59632

THOMAS L. JUDGE  
GOVERNOR

WILLIAM F. CONRAD  
SUPERINTENDENT

ROBERT H. HATTSON  
DEPT. OF INSTITUTIONS

TO: Ron Langworthy, Dr. Richard Swenson  
FROM: Steve Kanies  
DATE: December 10, 1975  
SUBJECT: Proposed functions of BRS&H Human Rights Committee

The Mental Disabilities Board of Visitors established by the 1975 Montana Legislature has the following among its duties is defined in Senate Bill #388.

Review and approve all behavior modification programs involving the use of noxious or aversive stimuli.

Review and approve experimental research.

Review and approve proposed "hazardous treatment" procedures.

Review each residents individualized habilitaiton plan.

It seems necessary that these duties be excluded from the role of a BRS&H Human Rights Committee.

The following are proposed as possible duties of the Boulder River School & Hospital Human Rights Committee.

1. Review and approve all restrictions on resident's rights.
2. Monitor implementation of "rights" sections of SB #388 and BRS&H policies and procedures and reports on findings to BRS&H Superintendent and Mental Disabilities Board of Visitors.
3. Serve as an independent review body responsible for investigating alleged violations of the rights of individuals and groups brought by BRS&H residents, their parents or guardians of other parties. Report to reporter of Alleged Rights Violations and Superintendent.
4. Monitor implementation and progress of "hazardous treatment" procedures approved by Mental Disabilities Board of Visitors.

5. In cases of experimental research approved by the Mental Disabilities Board of Visitors, the Human Rights Committee would be responsible to:
  - a. Oversee the selection process of S's for research.
  - b. Oversee that legally informed consent is obtained by adequate and appropriate methods.
  - c. Monitor continued willingness of S's to participate.
  - d. Monitor progress of research through site-visits.
6. Bring to the attention of appropriate persons and departments existing violation of human rights.
7. Review, monitor and assess the efficiency of existing and proposed methods and procedures for protecting the rights of Boulder residents. Report findings and recommendations to Superintendent and other appropriate persons.



# Boulder River School and Hospital

BOULDER, MONTANA 59632

THOMAS L. JUDGE  
CO-CHAIR

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0000000000000000  
WILLIAM F. CONYARD  
SUPERINTENDENT

0000000000000000  
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0000000000000000  
ROBERT H. MATTSON  
DEPT. OF INSTITUTIONS

January 6, 1976

Mr. Floyd McDowell  
School for the Deaf/Blind  
3911 Central Avenue  
Great Falls, Montana 59401

Dear Floyd:

Your name has been suggested to be a member of Boulder River School and Hospital's Human Rights Committee. Attached for your review are proposed Committee functions.

I look forward to your acceptance to serve on this Committee. It is something the institution has needed for years. Since there is no history to rely on, the Committee will more than likely develop by-laws, elect a chairman and meet the Boulder River School and Hospital management staff at its first meeting.

Travel and per diem expenses incurred by you for the purpose of this Committee will be paid by Boulder River School and Hospital. I would appreciate your answer by January 16, 1976.

Sincerely yours,

William F. Conyard  
Superintendent

cc: Dr. Robert Mattson  
Gus Hamerlynck

/ns

## PROPOSED FUNCTIONS OF BOULDER RIVER SCHOOL AND HOSPITAL HUMAN RIGHTS COMMITTEE

Review and approve all written restrictions as required in the Right to Treatment Bill (Senate Bill 383) which was enacted on July 1, 1975, on resident's rights.

Monitor implementation of "rights" sections of SB 388, BRS&H policies and procedures. Report on findings to BRS&H Superintendent.

Monitor implementation and progress of "hazardous treatment" procedures approved by Mental Disabilities Board of Visitors.

Recommendations regarding experimental research and be responsible to:

- a. Oversee the selection process of subjects for research.
- b. Oversee that legally informed consent is obtained by adequate and appropriate methods.
- c. Monitor continued willingness of subjects to participate.
- d. Monitor progress of research through site-visits.

Review, monitor and assess the efficiency of existing and proposed methods and procedures for protecting the rights of Boulder residents. Report findings and recommendations to Superintendent or his designee.

## BRS&H HUMAN RIGHTS COMMITTEE MEETING

The first meeting of the BRS&H Human Rights Committee was held on Tuesday, March 9, 1976. In attendance were Dr. John Dodd, Dr. Charles Horvath, Mr. Floyd McDonnell, Dr. Mark Mozer, Dr. Richard Swenson and Mrs. JoAnn Willis. Mr. Richard Moore was absent.

### I. General Business Conducted:

1. JoAnn Willis was elected chairperson of the committee by a unanimous vote of the members.
2. A procedure for approving programs involving aversive procedures between meetings of the committee was established. It was agreed that Dr. Richard Swenson can approve programs on the condition that they be presented to the committee at its next meeting. However, unusual or questionable programs can be approved by agreement of a quorum (four members) by telephone. The decision as to whether phone calls are warranted will be up to Dr. Swenson.
3. The next meeting is scheduled for Monday, May 10, 1976, at 9:00 A.M. in Building J. Committee members requested that copies of programs to be reviewed by the committee be sent to them in advance if possible.
4. In the future, the committee requested that written programs include brief information on all other programs a particular resident is enrolled in. Also, the age of the resident should be included.
5. The committee felt that its role is to approve written, individualized programs which involve procedures which may raise ethical or legal questions. Thus, the committee will not give blanket approval to procedures, but rather only as they are applied in individual circumstances. In most cases, the committee would like baseline data on behaviors to be presented, as well as documentation of other less restrictive methods that have been tried. Information on the criteria used to select the behavior to be modified and the procedure used would also be helpful.



II. Programs Reviewed:

- A. 1. Presenter: Greg Rague, HA V in the Group Home.
2. Program: A general procedure used to consequence temper tantrums of Mark B. was presented. Greg explained that if progress was not seen within three weeks the procedure would be modified. Mark is enrolled in various other skill acquisition programs.
3. Decision: The program was approved with the stipulations of a three (3) hour time limit on the positive practice procedure and a one (1) hour time limit on the quiet period. Greg will present data on the progress of the program at the next meeting.
- B. 1. Presenter: Curt Hasla, Supervisor of Cottage 12.
2. Programs: The programs presented tended to be standard operating procedures used to consequence various maladaptive behaviors exhibited by Bryan H., Tom S., Phil D., Steve W., Robert L., David O., Gary L., Bernie K., and Kelly C. As such, the members felt it was not the role of the committee to address itself to "standard procedures."
3. Decision: The committee saw no ethical or legal problems with the procedures but requested that behavioral data be taken and individualized programs be presented at the next meeting. Curt Hasla agreed to this decision.
- C. 1. Presenter: Jan Anderson, Supervisor of Cottage 14.
2. Programs:
  - a. A toileting program for Danny D. was presented. The program was difficult to understand as written, but a revised version is being done and will be distributed. Ms. Anderson presented the revised version verbally to the committee.
3. Decision: The committee approved the program as verbally presented with the stipulation that no meals be served to the resident in the bathroom area.
  - b. A Comprehensive Behavioral Program for Billy J. was approved. A progress report was requested to be presented at the next meeting.
  - c. A DRL program for Billy J. was approved. The committee recommended that BRS&H food service make special provisions for delaying meals as part of a program if possible. The committee stresses that no residents be denied access to any meal, but delaying a meal as part of a program is not objectionable, as long as the maximum allowable time between meals (14 hours) is not exceeded.
  - d. A Required Relaxation Program for Mike B. was approved with the stipulation of a one (1) hour time limit on the required relaxation procedure.



e. A Comprehensive Behavioral Program for Ray L. was approved with the stipulation of a one (1) hour maximum time limit on use of required relaxation.

f. An Independent Dressing Program for Tom B. was approved with the stipulation that a meal can be delayed as part of a program, but that access to a meal cannot be denied.

D. 1. Presenters: June Miller and Steve Dougherty, Supervisor and teacher, respectively in 104C, Deaf/Blind Unit.

2. Programs: A number of programs describing standard operating procedures for dealing with various maladaptive behaviors were presented. As such, the members felt the committee's role was not to approve these as they stood, but stated that they saw no objectionable aspects to the procedures.

3. Decision: It was agreed that individualized programs, preferably with baseline data and provisions for measuring progress would be presented at the next meeting.

The meeting was adjourned at 1:30 P.M.

rk

APPENDIX 7-A

REPORTS ON GALEN

## GALEN OVERVIEW

The Boulder River School and Hospital patients at Galen (64 total) are physically divided into three groups that are housed in three sections of the Hospital. All of the men (36) reside in Byram Hall, a building located directly behind the main Hospital (see Byram overview). The women (27) are divided into two groups that occupy portions of the second floor of the main hospital and Annex.

### ANNEX II

There are sixteen women presently residing in Annex II. The average age of these ladies is 68 years and the average length of institutionalization is 42 years. Each lady has her own room and television. Each room is equipped with a bed, bureau, mirror, washstand, easy chair and closet. The residents have access to their own clothing (with the exception of their coats and "best dresses" which are kept in a central community closet to prevent their misuse). The bureaus have scarves and are used to display various ceramic figurines and other handiwork made by the residents of Annex II. The rooms appear to be freshly painted and clean. Major articles of clothing for the residents are purchased approximately twice a year. The nurse in charge of Annex II orders most of these items from a catalogue. (Pantsuits seem to be a popular item at present). Smaller items such as underwear, stockings, etc. are purchased on an as needed basis.

The residents are awakened each morning at 5:30 a.m. Breakfast is served at 7 a.m., lunch at 11:30 a.m. and supper at 5:30 p.m. Bedtime is between 8:30 p.m. and 9:00 p.m. During the day, most of the ladies engage in sewing, crocheting, embroidering, ceramics, watching T.V. and visiting with each other. In summer months they are frequently escorted outside the hospital on short walks around the grounds, an activity that they seem to enjoy a great deal. One lady has her own sewing machine which she frequently uses to mend some of the other ladies' clothing.

As in Byram Hall, all meat is cut off the bone for the residents of Annex II. Most of the ladies are able to use a knife, fork and spoon. Eight ladies share a small dining room located in Annex II; the others eat in their own rooms. Not only does the small size of the dining room area dictate the above arrangement, but many of the ladies who eat separately are on special diets and there is less dissent expressed by them if they are not exposed to the regular diets.

Saturday is "treat day" for the women living in Annex II. On this day, they are given change for the coke and candy machines out of their own funds (residents at Galen are not allowed to keep money in their possession). Usually, at Christmastime they are taken on a day's shopping excursion to Butte and are allowed to spend about \$5 to purchase small gifts for each other or for themselves.

Most of the ladies attend either Catholic or Protestant services held in the chapel at the hospital each week. They also participate in the once-a-month birthday party which is put on for all of the Boulder transferred patients at Galen. Occasionally dances are held in a gymnasium for these people--an event that the

Several excursions from the institution, such as to the Ice Follies, are planned for these residents.

All bathing in Annex II is supervised and each of the ladies' hair is professionally done twice a week by a beautician who has a shop just down the hall from Annex II.

The average length of institutionalization is 42 years (both at Boulder River School and Hospital and at Galen. Most were transferred from Boulder River School and Hospital in 1963. In my opinion, due to their higher functional abilities, they probably augmented the regular labor force while at Boulder River School and Hospital. As a matter of fact, one lady tells of her duties at Boulder which included passing medications such as Dilantin and Phenobarbital, to other patients!

In talking with some of the residents in Annex II one gets the impression, at first, that some of the women--if required to relocate, would prefer not to associate with some of the others. But, I would like to point out that there is a definite hierarchy that exists among these women which should not be tampered with (considering that this has been established over the past 42 years). If only the "higher functioning" women were to be placed together or separately--the rhythm and order of their past lives will be destroyed which would have a devastating psychological effect on them.

#### CROCKETT II

There are 11 women presently living in Crockett II. The average age is 64 years. The average length of institutionalization is 43 years. Each lady shares a two bed room with another resident. Oftentimes the other person in the room is a mental patient, rather than developmentally disabled.

The atmosphere of this ward is much more hospital-like in appearance. There is not the individualization in decoration and extra things in the patients' rooms such as television, special bureau scarves, pictures, or handmade quilts, etc. on the beds. Many of these ladies are bed-ridden and the ones who are allowed to be up and allowed to walk around have very little to do. There is a day-room, a large cold room with a few couches, chairs, a few tables, and a large T.V. which blares all day long. This is shared with other mental patients on this ward.

I saw no evidence of books or magazines other than one or two that seemed to be in the personal possession of some of the mental patients. These ladies roam up and down the hall with obviously nothing to do. They do not have a choice of clothing. Clearly their clothing is in much poorer shape than those of the ladies in the Annex. Oftentimes they are dressed in hospital gowns and I am told that this is because they are "untidy", translated to be incontinent of urine and/or feces, and it is easier to keep them clean this way. They are given body baths twice a week, along with a shampoo. Their hair is cut in the beauty parlor or in their rooms, depending on whether they are ambulatory or not. These ladies are fed with security trays, which means the absence of any utensils or glasses that could be harmful to them. Paper or porcelain cups are therefore given to them rather than glasses. Nothing but a spoon is put on the tray. They are all for the most part

## ANNEX II:

<u>Born</u>	<u>Present Age</u>	<u>Committed</u>	<u>Institutionalization</u>
1912	64 yrs.	1933	43 yrs.
1912	64 yrs.	1940	36 yrs.
1904	72 yrs.	1946	30 yrs.
1906	70 yrs.	1933	43 yrs.
1899	77 yrs.	1928	48 yrs.
1904	72 yrs.	1931	45 yrs.
1892	84 yrs.	1933	43 yrs.
1909	67 yrs.	1959	17 yrs.
1923	53 yrs.	1937	39 yrs.
1904	72 yrs.	1935	37 yrs.
1905	71 yrs.	1918	58 yrs.
1924	52 yrs.	1963	13 yrs.
1951	46 yrs.	1942	34 yrs.
1899	77 yrs.	1913	63 yrs.
1906	70 yrs.	1924	52 yrs.
1893	78 yrs.	1910	66 yrs.

(Average age 68 yrs. Average length of institutionalization 42 yrs.)

## CROCKETT:

<u>Born</u>	<u>Present Age</u>	<u>Committed</u>	<u>Institutionalization</u>
1906	70 yrs.	1912	64 yrs.
1899	77 yrs.	1909	67 yrs.
1898	78 yrs.	1909	67 yrs.
1915	61 yrs.	1926	50 yrs.
1914	62 yrs.	1932	44 yrs.
1909	67 yrs.	1934	42 yrs.
1935	41 yrs.	1951	25 yrs.
1908	68 yrs.	1950	26 yrs.
1910	66 yrs.	1957	19 yrs.
1909	67 yrs.	1941	35 yrs.
1932	44 yrs.	1947	29 yrs.

(Average age 64 yrs. Average length of institutionalization 43 yrs.)



GENERAL FILE - CALEN

Byram

- #1 Bathing is supervised primarily for safety. All residents are supervised, however.
- #2 Live music seems to be well received by all. In the past this has occurred, not so often now.
- #3 Not much chance at Galen for close contact with animals. There are some on the grounds but for the most part the patients do not have any one to one contact with animals.
- #4 Outings are important to everyone.
- #5 The crafts Department at Galen is designed primarily for normal persons. It was originally put in there for people who were there on the alcohol program or in the hospital and for staff members. The activities there are first and foremost work in ceramics, the room is overcrowded with materials and supplies and it is not conducive to lower functioning persons or persons with multiple handicaps being able to go in there and work. There is no training supplied. The only kind of work that can be done is by those that already have some skills in working in ceramics.
- #6 "Institutional kleptomania".
- #7 I recommend that all testing be done in Byram unless otherwise indicated on individual charts. The third floor or whatever floor they have been doing it on over in the hospital portion is foreign territory for all those residents, it is frightening, unfamiliar and might present an overlay to the testing situation that would not allow the person to perform at their maximum.
- #8 Switch to an urban setting for most of these residents would be extremely difficult. They are used to the rural environment, no traffic, few people walking around, no traffic signals to watch out for, no blocks that all look alike, they would get lost very easily I think.
- #9 Shirley Kelly in Byram has started a new clothing program. She has received funding and she is ordering clothing on an individual basis for each resident. It is interesting to note when I was down there two weeks ago the new clothing was just coming in for the residents and those who had received their new clothes were extremely pleased with them. Two weeks since then, going back down, most everyone has at least one item of their own personal new and brightly colored, well fitting clothing to wear. I was subjected to a half-hour dress parade of everyone showing off their new clothes and apparently people who were not able to identify their clothing before now certainly know what belongs to them now. They take a tremendous amount of pride in it. It is also creating problems for the staff because the residents have become extremely finicky about how they look now and if there is a button missing or a tear anywhere, or anything that seems to be wrong with their clothes, they want it fixed immediately, where as before they would wear anything that hung on their bodies.
- #10 Prior to meals many of the residents at Byram Hall are required to pick up bibs at the desk, this has been in practice for some time, it cuts down on the dirt etc.
- #11 Religious services. These are held at the chapel there at Galen, they have trouble with what Shirley refers to as the "40 ~~th~~ *th*" the residents at Byram, going to a regular church service because when the plate was passed they thought this was the time they could help themselves to the money that was in it. Now they have two services: on Monday the Catholic service takes place and Tuesday the Protestant services takes place. Most of the residents at Byram attend either one or both of these services.



#12

Shirley keeps making the point that she feels that many of the residents "thinking process and memory seems to have stopped" at the point they were committed to Boulder River School and Hospital, and subsequently on over to Galen.

She feels that the reason for this is a lack of stimulation or input at the time of commitment. In other words residents there who are 35 years old can tell you about their lives prior to being admitted to the institution as if it were just yesterday, but it is clear that these were events that happened to very small children and they hang on to those things, and the rest does not seem to make any difference to them.

#13 Lights are turned off except for two night lights in the hall that are dimmed at night. There are some of the patients that are awakened during the night to go to the bathroom and when Pat Dunn, a nurse's aid in Byram, is there he insists that the residents say grace before meals. Some join in in this procedure.

#14 Toilet habits for most everyone are very good, only one person occasionally is incontinent and that note will be made on his chart.

#15 Shirley feels that all residents need to increase their attention span, right now they have not developed that resource within themselves, therefore anything new does not hold their interest very long.

Ann Berkley, Social Worker

(University of Montana, Dept. of Social Work)

ADDITIONAL NOTES :

APPENDIX 8-A

BOARD OF VISITORS BUDGET FY '76-'77

on soft diets, or have meat cut from the bone as for the rest of the institution. The ladies on this wing do not participate in any recreational activities that are held in the institution, such as the ladies on the Annex experience. There is a central recreational room which also doubles as the dining room. The ambulatory residents are allowed to eat there. The others are served individually in their rooms, either in bed or at tables.

They arise at 7:00 in the morning and retire between 8 and 9 p.m. It is important to note that the staff on Crockett is primarily concerned with administering physical nursing care with close observation to diet and hygiene with very little attention given to personal or psychological needs. At this time I am unable to say whether these women have formed any close relationships with their peers, I am inclined to think not. My first visit to this ward in December was very difficult for me in that I considered the nursing care to be substandard. The smell of urine was extremely strong, and the general physical care of the patients seemed to be substandard. On my return in February there had been a change in the personnel on this floor and I did observe far better nursing care being administered to the patients. Because of this change in personnel it is also difficult to ascertain some vital information regarding the persons placed there from Boulder in that the new person has only been there to observe them for the past two months, does not know any sort of social or family contacts that have transpired between these patients and anyone from the outside. She had a difficult time responding to whether or not there were any close relationships among the patients there on the floor.

It is my intention this week to talk with the person who has the general charge of both Annex and Crockett to try to fill in some of these details. It will be interesting to find out how long it has been since any of the bed patients in Crockett have been outside of even the hospital.

ANN BERKLEY  
SOCIAL WORKER  
(University of Montana, Dept. of Social Work)  
AB:jj

PROPOSED BUDGET FOR FY '76/'77

As you know, we have an appropriation of \$50,000 for the biennium and we have been cautioned to staff within the constraints of \$30,000 per year. This is required in order to project operations for the next fiscal period which would not require additional funds. This does not mean we should not prepare a budget proposal reflecting realistic operations which will obviously exceed the current appropriations.

The result is that we do have a considerable balance due to the vacancy savings arising from our deferral of staffing until we were confident of our tasks. As a consequence, we have funds to pursue our mission with "one-time" resources - hopefully these will become continuing. Specifically - the utilization of consultants.

Narrative Justification for Staff:

- i. The board has unanimously agreed that we need a full-time executive secretary to:
  - a. coordinate board activities;
  - b. serve as the contact/liason with the public, residents, and staff of facilities and agencies under our jurisdiction;
  - c. serve as staff investigator for the Board;
  - d. act as the legal advocate of the Board with the courts.

Minimal qualifications for the position are that the candidate be a licensed attorney with a demonstrated interest in mental health and developmental disabilities. A thorough knowledge of the enabling state laws as well as correlated state and federal laws will be expected. A familiarity with Montana and its legal and human service system is also expected.

- ii. Although the board and the forementioned staff need considerable support services we also recognize the fiscal limb. As a consequence, it is agreed that the Board will accept a temporary arrangement. The administrative assistant to the Board secretary will serve as recording secretary to the Board for the remainder of the biennium or until additional funds are located for an alternative staffing.
- iii. Budget status 31 March '76

Balance noted	\$ 29,269.66
Outstanding: estimated	
Dr. Harr	300.00
Dr. Rochford	700.00
Dr. Atthowe	700.00
Board - travel and honorarium	300.00
Total	2,000.00

## Anticipated to 1 July:

Board, honorarium	
3 x \$25 x 6 days	450.00
Board travel	
Helena April, May	450.00
Galen	
Executive Secretary 1.5 months	1,875.00
Recording Secretary	N/A
Rent and phone 1.5 months	300.00
Staff travel	325.00
Total:	\$ 3,400.00

Estimated balance 1 July for current FY \$24,869.00

We will request that this amount will be brought forward for the next FY. Thus the estimated balance for the FY '76/'77 is \$54,869.00.

## iv. Proposed budget for FY '76/'77:

Staff

Executive Secretary	1.0 F.T.E.	\$ 15,000
Recording Secretary	.2 F.T.E.	2,250
		<u>17,250</u>
Indirect @ 15%		2,588
		<u>\$ 19,838</u>

Support

Rent @ \$75	900
Communications @ \$75	900
Equipment and supplies	200
Travel @ \$200 per month	2,400
	<u>4,400</u>

Board Visits and Meetings

Honorarium 4 x \$25 x 24 days	\$ 2,400
Travel 5 x \$70 x 12 trips	4,200
Expenses 5 x \$25 x 24 days	2,400
	<u>\$ 9,000</u>

Staff for visits

Travel 2 x \$70 x 12	\$ 1,680
Expenses 2 x \$25 x 24	1,200
	<u>\$ 2,880</u>

Estimated need FY '76/'77: \$ 36,118

Available surplus for consultants: \$ 18,751

